# TRICARE Beneficiary Handbook

*Your guide to program benefits*

TRICARE North

Department of Defense
United States of America

## *Important Information*

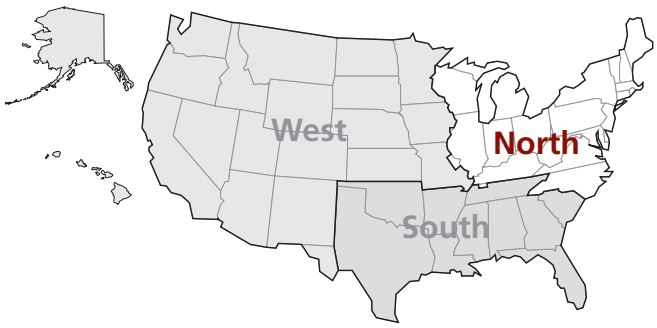
| | |
|---|---|
| Health Net Federal Services, Inc. (Health Net): | 1-877-TRICARE (1-877-874-2273) |
| Health Net Web Address: | www.healthnetfederalservices.com |
| TRICARE Information Service: | 1-888-DoD-CARE (1-888-363-2273) |
| TRICARE National Web Address: | www.tricare.osd.mil |
| TRICARE Mail Order Pharmacy *(Express-Scripts)*: | 1-866-DoD-TMOP (1-866-363-8667) |
| TRICARE Retail Pharmacy *(Express-Scripts)*: | 1-866-DoD-TRRx (1-866-363-8779) |

| |
|---|
| Your Primary Care Manager: |
| Other Providers: |
| Name: |
| Name: |
| Name: |
| Behavioral Health Care Provider: |

***An Important Note About TRICARE Program Changes***

This "TRICARE Beneficiary Handbook" will help you learn about your TRICARE benefits and services. At the time of printing, the information in this booklet is current. It is important to remember that TRICARE policies and benefits are governed by public law. Changes to TRICARE programs are continuous, and new benefits are added regularly as we continue to make TRICARE a better program for you. For the most recent information, contact your regional contractor, Health Net Federal Services, Inc. at 1-877-TRICARE (1-877-874-2273) or visit them online at www.healthnetfederalservices.com. More information regarding TRICARE, including the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, can also be found online at www.tricare.osd.mil.

# *TRICARE: Making a Strong Program Even Better*




### North Region

**1-877-TRICARE (1-877-874-2273)**
**www.healthnetfederalservices.com**

### West Region

**1-888-TRIWEST (1-888-874-9378)**
**www.triwest.com**

### South Region

**1-800-444-5445**
**www.humana-military.com**

TRICARE is the Department of Defense (DoD) health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE's primary objectives are to optimize the delivery of health care services in military treatment facilities (MTFs) and attain the highest level of beneficiary satisfaction through the delivery of a world class health care benefit. TRICARE brings together the health care resources of the Army, Navy, Air Force, and Coast Guard and enhances their services with networks of civilian health care professionals.

TRICARE's vision is to provide a world-class health system that meets all wartime and peacetime health care needs for the active duty and retired military and their families. TRICARE is available worldwide to all eligible beneficiaries. The TRICARE program continues to evolve with the ever-changing needs of the uniformed services, both active and reserve components. Each year, improvements are made that make this strong program even better.

# Health Net Proudly Serves Its Beneficiaries One at a Time

The DoD has partnered with Health Net Federal Services, Inc. (Health Net) to assist in operating the TRICARE program for more than 2.78 million beneficiaries in the TRICARE North Region. The North Region includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin, and portions of Tennessee (Ft. Campbell area), Iowa (Rock Island Arsenal area), and Missouri (St. Louis area). Health Net is committed to preserving the integrity, flexibility, and durability of the Military Health System (MHS) by offering you access to the finest health care services available.

# Table of Contents


## Eligibility for TRICARE

TRICARE Choices . . . . . 4
Updating DEERS . . . . . 5
Uniformed Services or Military ID Cards . . . . . 5

## TRICARE Program Options

TRICARE Prime . . . . . 6
TRICARE Extra and TRICARE Standard . . . . . 8
TRICARE Prime Remote and TRICARE Prime Remote for Family Members . . . . . 8
TRICARE For Life . . . . . 9
TRICARE Plus . . . . . 10
TRICARE Choices for the Reserve Component . . . . . 10
TRICARE Dental Programs . . . . . 11
Uniformed Services Family Health Plan . . . . . 12
TRICARE Overseas . . . . . 13
Program for Persons with Disabilities . . . . . 13
Transitional Health Care Benefits . . . . . 14

## What TRICARE Covers

Emergency and Urgent Care . . . . . 15
Medical and Surgical Covered Services . . . . . 15
Clinical Preventive Services . . . . . 19
Maternity Care . . . . . 22
Behavioral Health Care Services . . . . . 23
TRICARE Pharmacy Program . . . . . 24

## Limitations and Exclusions

Services or Procedures with Significant Limitations . . . . . 26
Exclusions . . . . . 27

## Understanding TRICARE Costs and Fees

TRICARE Annual Deductible . . . . . 28
TRICARE Prime Point-of-Service Option . . . . . 28
Catastrophic Cap Benefit . . . . . 28
Other Health Insurance . . . . . 29
Third Party Liability . . . . . 29
TRICARE Explanation of Benefits . . . . . 29

## Your TRICARE Claims

Claims for Active Duty Service Members . . . . . 30
Claims for Dual-Eligible Beneficiaries (Medicare and TRICARE) . . . . . 30
Submitting Claims While Transitioning to the TRICARE North Region . . . . . 30

## Ensuring Customer Satisfaction

Appealing a Decision . . . . . 32
Grievances . . . . . 33
Assistance with Collection Activities . . . . . 34
Fraud and Abuse . . . . . 34

## For Information and Assistance

Regional Information Resources . . . . . 35
National Information Resources . . . . . 36

## Beneficiary Tools

Common TRICARE Acronyms . . . . . 37
Glossary of Terms . . . . . 38
Procedures and/or Services Requiring Prior Authorization . . . . . 41

**Index** . . . . . 42

# Eligibility for TRICARE

## TRICARE Choices

TRICARE is available to eligible beneficiaries from any of the seven uniformed services of the United States: the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). Several program options are available for TRICARE's unique beneficiary population. The chart below lists the options available to you. Each of these programs is described in more detail later in this guide.

| Beneficiary Category | Your Options | Enrollment Requirements |
|---|---|---|
| Active duty service member (ADSM) | TRICARE Prime | Enroll with your regional contractor and select a primary care manager (PCM). |
| Active duty family member (ADFM)—Spouses and unmarried children up to age 21 (23 if enrolled in college full time) | TRICARE Prime<br>TRICARE Extra<br>TRICARE Standard | If you choose TRICARE Prime, enroll with your regional contractor and select a PCM. If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider. |
| Uniformed services retirees under age 65 and eligible family members | | |
| ADSM who lives and works more than 50 miles or an hour drive time from an MTF | TRICARE Prime Remote (TPR) | Enroll with your regional contractor and select a network PCM (if available). |
| Family members residing with ADSM who lives and works more than 50 miles or an hour drive time from an MTF | TRICARE Prime Remote for Active Duty Family Members (TPRADFM)<br>TRICARE Extra<br>TRICARE Standard | If you choose TPRADFM, enroll with your regional contractor and select a network PCM (if available). If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider. |
| Member of the Reserve Component on active duty orders (activated) | TRICARE Prime (treated as ADSM) or TPR (if you meet eligibility requirements) | Enroll with your regional contractor and select a PCM. |
| Family of Reserve Component member activated for more than 30 days | TRICARE Prime<br>TPRADFM<br>TRICARE Extra<br>TRICARE Standard | If you choose TRICARE Prime or TPRADFM, enroll with your regional contractor and select a PCM (if available). If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider. |
| Medicare-eligible beneficiary under age 65 | TRICARE Prime<br>TRICARE Extra<br>TRICARE Standard | Enroll in Medicare Part B (required for all Medicare-eligible beneficiaries except for ADFM under age 65). If you choose TRICARE Prime, enroll with your regional contractor and select a PCM. If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider who accepts Medicare. |
| Medicare-eligible beneficiary age 65 and over | TRICARE For Life (TFL) | Enroll in Medicare Part B and seek care from any TRICARE-authorized provider who accepts Medicare. |
| Congressional Medal of Honor recipients and their immediate family members | TRICARE Prime<br>TRICARE Extra<br>TRICARE Standard<br>TFL (if age 65 and over) | If you choose TRICARE Prime, enroll with your regional contractor and select a PCM. If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider. If age 65 and over, enroll in Medicare Part B and seek care from any TRICARE-authorized provider who accepts Medicare. |
| Certain former spouses of active or retired military service members | | |

*This chart does not list every eligible beneficiary category. To find out if you're eligible for TRICARE, call DEERS at 1-800-538-9552 or visit the TRICARE Web site at www.tricare.osd.mil for a complete list of eligible beneficiary categories.*

## Updating DEERS

Eligibility for TRICARE is determined by the Defense Enrollment Eligibility Reporting System (DEERS), a database of uniformed services members (sponsors), family members, and others worldwide who are entitled under the law to TRICARE benefits. Active duty and retired service members are automatically registered in DEERS, but it's the sponsor's responsibility to ensure that his or her eligible family members are registered correctly in DEERS. All sponsors should ensure that their family members' status (marriage, divorce, new child, etc.), residential address, telephone numbers, and e-mail address are current in DEERS so that TRICARE can send out information and have claims processed quickly and accurately.

DEERS information may be verified by calling DEERS at 1-800-538-9552 or the nearest uniformed services personnel office where military identification (ID) cards are issued. Sponsors or registered family members may make address and contact information changes. However, only the sponsor can add or delete a family member from DEERS, and proper documents are required, such as a marriage certificate, divorce decree, and/or birth certificate. Beneficiaries may update their DEERS information in one of the following ways:

- Visit a uniformed services personnel office. The nearest uniformed services personnel office can be located online at www.dmdc.osd.mil/rsl.
- Call 1-800-538-9552.
- Fax address changes to DEERS at 1-831-655-8317.
- Mail the address change to:
  Defense Manpower Data Center Support Office
  ATTN: COA
  400 Gigling Road,
  Seaside, CA 93955-6771
- Update addresses electronically at www.tricare.osd.mil/DEERSAddress.

If you make any changes to your information in DEERS, please contact Health Net and your MTF so your most up-to-date information will be on file.

## Uniformed Services or Military ID Cards

To use TRICARE benefits, you must have a valid uniformed services or military ID card, and you must be listed in the DEERS database. The ID card states on the back, in the "Medical" block, whether you are eligible for medical care from military or civilian sources. Children under age 10 can normally use the ID card of their parent or guardian, but they must be registered in DEERS. At the age of 10, the child's sponsor should obtain an ID card for the child. Children under 10 should also have an ID card of their own when in the custody of a parent who is not eligible for benefits.

### Newborn Enrollment and DEERS

New parents should register newborns in DEERS as soon as possible after birth to ensure continued eligibility for TRICARE. To establish TRICARE eligibility for a newborn in DEERS, parents or legal guardians must submit a certificate of "live birth" from a hospital or TRICARE approved birthing center. They must also provide a copy of a verified and approved DD Form 1172 "Application for Uniformed Services Identification and Privilege Card" signed by the sponsor.

A newborn is covered as a TRICARE Prime beneficiary for the first 120 days after birth—as long as one additional family member is enrolled in TRICARE Prime or TRICARE Prime Remote. After the initial 120 days, any claim submitted for a newborn will process as TRICARE Standard until the infant is enrolled in DEERS and TRICARE Prime, or the infant's TRICARE Standard eligibility ends. Eligibility for TRICARE Standard ends 365 days after birth for any newborn who is not properly registered in DEERS.

# TRICARE Program Options

TRICARE's family of programs offers comprehensive health and dental benefits to every TRICARE beneficiary category. It's important to understand the choices available to choose the best option for you and your family.

## TRICARE Prime

TRICARE Prime offers fewer out-of-pocket costs than any other TRICARE option. TRICARE Prime beneficiaries receive most of their care from a military treatment facility (MTF), supported by the Health Net Federal Services, Inc. (Health Net) provider network, and are guaranteed access to care. To enroll in TRICARE Prime, you will complete an enrollment form and select, or will be assigned, a primary care manager (PCM) who provides and coordinates your care, maintains your patient health records, refers you to specialists, and files claims for you. Specialty care must be arranged by your PCM and approved by your MTF or Health Net to be covered under TRICARE Prime. TRICARE Prime also offers enhanced coverage for vision and clinical preventive services. Specialty care received without a referral will be covered under the TRICARE Prime point-of-service (POS) option which includes a deductible, higher copayments, and cost-shares.

### Eligibility for TRICARE Prime

TRICARE Prime is available to active duty service members, family members, survivors, and eligible former spouses of active duty personnel; retirees, their family members, and survivors under age 65; and to members of the Reserve Component and their families if the sponsor is activated for more than 30 consecutive days. All eligible beneficiaries must be registered in the Defense Enrollment Eligibility Reporting System (DEERS) and reside in a service area where TRICARE Prime is offered.

### Enrollment

To participate in TRICARE Prime, you must complete a TRICARE Prime enrollment form and submit it to Health Net. Enrollment forms are available on the Health Net Web site at www.healthnetfederalservices.com, by visiting a TRICARE Service Center (TSC), or by calling 1-877-TRICARE (1-877-874-2273). **Active duty service members are automatically covered under the TRICARE Prime benefit but are still required to complete an enrollment form.** There is no enrollment fee for active duty family members. Retirees and their family members must pay an annual enrollment fee of $230 for an individual or $460 for a family to enroll in TRICARE Prime. Payments can be made in annual or quarterly installments if paying by check, credit card, or money order. If paying by allotments or electronic funds transfer, the installments may be made monthly.

Enrollment in TRICARE Prime is continuous. You may choose to disenroll, or you may be disenrolled due to a move to a non-TRICARE Prime service area or for nonpayment of enrollment fees. If you choose to disenroll from TRICARE Prime before your annual enrollment renewal date, or are disenrolled for nonpayment, you may be subject to a one-year lockout. The lockout provision does not apply to active duty family members of E-1 through E-4. Please note that any change in status (e.g. active duty to retired or demobilization) will cause a disenrollment from TRICARE Prime. When there is a status change you MUST re-enroll in TRICARE Prime to maintain your coverage.

### TRICARE Prime Access Standards

Another advantage of enrolling in TRICARE Prime is the TRICARE Prime access standards. You are guaranteed an appointment within the following standards:

- The wait time for an urgent care appointment shall not exceed 24 hours.
- The wait time for a routine appointment shall not exceed one week.
- The wait time for a specialty care appointment or wellness visit shall not exceed four weeks (28 days).

Additionally, under normal circumstances, your travel time may not exceed 30 minutes from your home to your PCM's office for primary care, and you should not have to travel more than one hour from your home for referred specialty care.

## Referrals for Specialty Care

A referral is the process by which your PCM or other health care provider refers you to another professional or ancillary provider for specialized medical services. The following rules apply to TRICARE Prime beneficiaries for specialty care referrals:

- A referral is required for all specialty care when you reside within an MTF Prime Service Area (a geographic area located around the MTF)
- A referral is required for all non-network specialty care unless you are utilizing the TRICARE Prime POS option
- If enrolled to an MTF, a PCM referral is required for all network provider specialty care

When specialty care or hospitalization is required, civilian PCMs must contact Health Net first at 1-877-TRICARE (1-877-874-2273), and Health Net will determine if the services are available within the MTF or network.

In support of delivering high quality health care, Health Net utilizes HealthShare, a Web-based tool, to refer beneficiaries to hospitals with the most favorable outcomes. You can access the HealthShare tool through the Health Net Web site at www.healthnetfederalservices.com to compare hospitals and become more knowledgeable about hospital care.

## TRICARE Prime Travel Entitlement

If you are referred by your PCM for specialty care at a location more than 100 miles from your PCM, you may be eligible to have your "reasonable travel expenses" reimbursed by TRICARE. You must have a valid referral and travel orders from a TRICARE representative at the MTF where you are enrolled or from the TRICARE Regional Office if your PCM is a TRICARE network provider.

Reasonable travel expenses are the actual costs incurred when traveling such as meals, gas/oil, tolls, parking, and tickets for public transportation (i.e. airplane, train, bus, etc.). You must submit receipts for expenses above $75. You are expected to use the least costly mode of transportation, and government rates will be used to estimate the reasonable cost. The actual costs of lodging (including taxes and tips) and the actual cost of meals (including taxes and tips, but excluding alcoholic beverages) may be reimbursed up to the government rate for the area concerned.

A parent, guardian, or other adult family member* is authorized to travel with a non-active duty TRICARE Prime-enrolled patient as a non-medical attendant (NMA). If the NMA is not the parent, he or she must be 21 years of age. The NMA is not required to be enrolled in TRICARE Prime or to be TRICARE-eligible. The patient, however, must be enrolled in TRICARE Prime.

This entitlement does not apply to expenses incurred by active duty service members or active duty family members residing with their sponsors overseas, which are reimbursed by other travel entitlements. For additional information about the TRICARE Prime travel entitlement and NMA travel entitlement, visit the TRICARE Web site at www.tricare.osd.mil/primetravel.

## Getting Care While Traveling

For emergencies while traveling away from home, you should dial 911 or go directly to the nearest hospital emergency department. You (or family members on your behalf) should notify your PCM or regional contractor within 24 hours of receiving emergency medical care to allow your doctor the opportunity to arrange for your continuing treatment.

**By statute, the NMA must be a parent, legal guardian, or other adult family member. If the NMA family member is active duty or a DoD civilian employee authorized by the MTF or TRICARE Regional Office to accompany a non-active duty TRICARE Prime enrollee as an NMA, he or she is entitled to TDY allowances (per diem and mileage), not actual expenses. If the NMA family member is a civilian not employed or affiliated with the DoD, they are authorized for reimbursement of reasonable travel expenses incurred.*

For treatment of a nonemergency medical condition that cannot wait until you return home, you should coordinate with your PCM before seeking care. You may also call Health Net at 1-877-TRICARE (1-877-874-2273) for assistance in coordinating out-of-area care. If you do not receive a referral from your PCM that has been authorized by Health Net for nonemergency care obtained out of area, your care may be covered under the point-of-service (POS) option, which includes a deductible, higher copayments, and cost-shares.

For additional information about enrolling in TRICARE Prime, visit the Health Net Web site at www.healthnetfederalservices.com or call 1-877-TRICARE (1-877-874-2273) to learn more about TRICARE Prime or to request a TRICARE Prime Enrollment Package.

## TRICARE Extra and TRICARE Standard

TRICARE Extra and TRICARE Standard are available for TRICARE-eligible beneficiaries who are not able to or who choose not to enroll in TRICARE Prime. Active duty service members are not eligible for TRICARE Extra or TRICARE Standard. There is no enrollment required for either option—no annual enrollment fees and no enrollment forms. Beneficiaries are responsible for annual deductibles and cost-shares.

TRICARE Extra is a preferred provider option (PPO). This means you choose a doctor, hospital, or other medical provider within the Health Net provider network to take advantage of lower costs and less paperwork.

TRICARE Standard is a fee-for-service option. With TRICARE Standard, you may seek care from any TRICARE-authorized provider. The following chart shows the main differences between TRICARE Extra and TRICARE Standard.

To locate a medical provider in the network, visit the Health Net provider directory online. If you are already seeing a provider or want to begin seeing a provider who is not in the TRICARE network, contact Health Net to find out if the provider is TRICARE-authorized. You can also have your provider call Health Net to learn how to become a TRICARE network provider.

## TRICARE Prime Remote and TRICARE Prime Remote for Family Members

TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) provide active duty service members in the United States and their eligible family members with the TRICARE Prime option while they are assigned to remote duty stations (typically more than 50 miles or an hour drive time away from the nearest MTF).

### Eligibility for TRICARE Prime Remote

The following TRICARE beneficiary categories are eligible for TPR or TPRADFM:

#### Active Duty Service Members

Active duty service members (ADSMs) under full-time orders with a permanent duty assignment, who live and work more than 50 miles or an hour drive time from an MTF (in TPR-designated ZIP codes), are required to

### Differences between TRICARE Extra and TRICARE Standard

| | TRICARE Extra | TRICARE Standard |
|---|---|---|
| Provider Type | In network | Not in network, but still an authorized provider |
| Cost-share after deductibles | 15% for active duty families<br><br>20% for retirees and their families | 20% for active duty families; nonparticipating providers may also "balance bill" up to 15% above the TRICARE allowable charge<br><br>25% for retirees and their families; nonparticipating providers may also "balance bill" up to 15% above the TRICARE allowable charge |

enroll in TPR. In some cases, where geographic boundaries create undue hardship for travel, service members living closer than 50 miles may be eligible for TPR. Service members may verify their eligibility based on location by visiting the TPR Web site at www.tricare.osd.mil/remote.

### Active Duty Family Members

Active duty family members (ADFMs) residing with their TPR-enrolled sponsors are eligible for TPRADFM and must enroll to enjoy the benefit. Family members who are enrolled in TPRADFM may remain enrolled even if the sponsor receives unaccompanied permanent change of station (PCS) orders as long they continue to reside in the same TPR location.

### Reserve Component Family Members

Reserve Component (RC) family members are eligible for TPRADFM if their sponsor is activated for more than 30 consecutive days and the family members reside with their sponsor (within a TPR-designated ZIP code) upon activation or effective date of orders. The activated reservist (sponsor) is not required to be eligible for, or enrolled in TPR for their family members to be eligible for TPRADFM.

RC family members must enroll in TPRADFM in order to enjoy the benefit. Once enrolled in TPRADFM, RC family members who continue to reside in the location where they enrolled may remain in TPRADFM for the entire period of the sponsor's activation, regardless of any changes in the sponsor's duty location.

**Example:**

**Staff Sergeant (SSG) James Smith of the U.S. Army Reserve lives with his family in Smalltown, Vermont. He receives orders assigning him to his local Reserve unit for 180 days. His family decides to enroll in TPRADFM. Two months later, SSG Smith receives new orders deploying him to an overseas location for six months. There will be no break in his activation and he will mobilize from his unit. His family continues to reside in Smalltown, Vermont, so they may remain enrolled in TPRADFM. If, however, they decide to move while SSG Smith is overseas, they will not be able to remain enrolled in TPRADFM, even if they move to a different TPR-designated ZIP code area. They will remain eligible for TRICARE Extra or TRICARE Standard. If they move to a location where TRICARE Prime is available, they can enroll in TRICARE Prime.**

### Enrolling in TPR and TPRADFM

Eligible ADSMs must enroll in TPR and complete an enrollment form. Family members of eligible active duty service members may enroll in TPRADFM or continue to receive care under TRICARE Extra or TRICARE Standard with applicable cost-shares and deductibles. To enroll in TPR and TPRADFM, an enrollment form must be completed and submitted to Health Net.

To see if you reside in a designated TPR service area, visit the TPR Web site at www.tricare.osd.mil/remote. Enrollment forms are available on the Health Net Web site at www.healthnetfederalservices.com or by calling 1-877-TRICARE (1-877-874-2273). View the TRICARE Prime Remote Handbook on the Health Net Web site to learn more about how TPR and TPRADFM work.

## TRICARE For Life

TRICARE For Life (TFL) is TRICARE's Medicare-wraparound coverage for TRICARE beneficiaries age 65 and over who become entitled to Medicare Part A and purchase Medicare Part B. TRICARE pays secondary to Medicare beginning on the first day of the month that you turn 65.

### Covered Services

- For services covered by both Medicare and TRICARE, Medicare will pay first and TRICARE pays second.
- For services covered by TRICARE but not Medicare, TRICARE will pay its portion and you are responsible for applicable TRICARE deductibles and cost-shares.

- For services covered by Medicare but not TRICARE, Medicare is the only payer, and you are responsible for Medicare cost-shares.
- For services not covered by Medicare or TRICARE, you are responsible for the entire bill.

For services received from a civilian provider, the provider will first file claims with Medicare. Medicare will pay its portion and automatically forward the claim to TRICARE for processing. TRICARE will send its payment for the remaining beneficiary liability directly to the provider. Beneficiaries will receive a Medicare summary notice and a TRICARE explanation of benefits (EOB) indicating the amount paid to the provider. For more information about TFL claims, see the description of claims for dual-eligible beneficiaries in the section entitled, "Your TRICARE Claims." View the TFL brochure on the Health Net Web site at www.healthnetfederalservices.com to learn more about TFL.

## TRICARE Plus

TRICARE Plus is a primary care enrollment program that is offered at selected MTFs. All beneficiaries eligible for care in MTFs (except those enrolled in TRICARE Prime, a civilian HMO, or Medicare HMO) can seek enrollment for primary care under TRICARE Plus—where it is available. Non-enrollment in TRICARE Plus does not affect TFL benefits or other existing programs. You should contact your local MTF to find out if they participate in TRICARE Plus.

## TRICARE Choices for the Reserve Component

Members of the Reserve Component (RC) who are called to active duty for more than 30 consecutive days are eligible for TRICARE, the same as any ADSM. Families of these individuals become eligible for TRICARE if the sponsor is called to active duty for more than 30 consecutive days. To ensure family members are eligible for TRICARE upon activation, sponsors must register their family members in DEERS.

### Programs Available to the Reserve Component

Family members of the RC become eligible for TRICARE Extra and TRICARE Standard on the first day of the military sponsor's active duty status if his or her orders are for more than 30 consecutive days or if the orders are for an indefinite period. They also become eligible for the TRICARE Pharmacy Program and may have prescriptions filled at MTF pharmacies, through the TRICARE Mail Order Pharmacy (TMOP), and at retail network and non-network pharmacies. The TRICARE Pharmacy Program has its own costs separate and apart from all other programs. See the section entitled, "What TRICARE Covers" for more information about the pharmacy benefit.

Eligible family members may enroll in TRICARE Prime (or TRICARE Prime Remote if distance eligibility requirements are met) if their

sponsor is called to active duty for more than 30 consecutive days. There are no enrollment fees or copayments for family members, but enrollment forms must be completed, and MTFs or network providers must be used, if available. Many RC families may have continuing relationships with providers who are not in the TRICARE Prime network. In these cases, enrolling in TRICARE Prime may not be the best choice—instead; using TRICARE Standard can be the most flexible option, even though beneficiaries may be required to pay a share of the cost of health care. If family members are eligible for the TRICARE Reserve Family Demonstration Project (see below), the TRICARE Standard annual deductible will be waived.

### TRICARE Reserve Family Demonstration Project

TRICARE Reserve Family Demonstration Project participants are limited to families of Reserve and National Guard members called to active duty for periods of more than 30 consecutive days in support of operations that result from the terrorist attacks of September 11, 2001, under Executive Order 13223, 10 U.S.C. 12302, 10 U.S.C. 12301(d), or 32 U.S.C. 502(f). Such operations include, for example, OPERATIONS ENDURING FREEDOM, NOBLE EAGLE, and IRAQI FREEDOM. TRICARE Reserve Family Demonstration Project components include:

- Waiver of TRICARE Standard annual deductibles
- Waiver of the TRICARE allowable charge under TRICARE Standard
- Waiver of requirement to obtain nonavailability statements for nonemergency inpatient care

### Temporary Reserve Health Care Benefits for 2004

The recently enacted Emergency Supplemental Appropriations Act and the National Defense Authorization Act for Fiscal Year 2004 authorized temporary health care benefits for TRICARE eligibility for eligible Reserve Component sponsors and their family members. The TRICARE Management Activity (TMA) is working closely with Reserve Affairs and the uniformed services to implement these temporary benefits for the Reserve Component and their families. Please visit the TRICARE Web site at www.tricare.osd.mil for new information about these temporary benefits as the details are made available. Additionally, information about the new benefits will be highlighted in newsletters, bulletins, and other educational materials in the future.

For additional information about TRICARE benefits available to the RC, visit the TRICARE Web site at www.tricare.osd.mil.

## TRICARE Dental Programs

TRICARE currently offers two dental programs: the TRICARE Dental Program and the TRICARE Retiree Dental Program. These programs are separate from the TRICARE medical program and have their own eligibility criteria and fees.

### TRICARE Dental Program

The TRICARE Dental Program (TDP) is a voluntary dental insurance program administered by United Concordia Companies, Inc. (UCCI). TDP is available to eligible ADFMs, Selected Reserve and Individual Ready Reserve (IRR) members, and their eligible family members. Active duty personnel (and Reservists called to active duty for a period of more than 30 consecutive days) are not eligible for TDP. They receive dental care from military dental treatment facilities. Former spouses, parents, parents-in-law, disabled veterans, foreign military personnel, and uniformed services retirees, and their families are not eligible for TDP. Other details of TDP benefits, requirements, and restrictions can be found at the UCCI Web site at www.ucci.com/was/ucciweb/home.jsp.

### TRICARE Retiree Dental Program

The TRICARE Retiree Dental Program (TRDP) is a voluntary dental insurance program administered by the Federal Services division of Delta Dental Plan (DDP) of California. TRDP offers comprehensive, cost-effective dental coverage for uniformed service retirees and their eligible family members, certain surviving

family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors. Other details of TRDP benefits, requirements, and restrictions can be found at the DDP Web site at www.trdp.org.

## Uniformed Services Family Health Plan

The Uniformed Services Family Health Plan (USFHP) is an extra TRICARE Prime option available to families of active duty military, retirees, and their eligible family members, including those age 65 and over, through networks of community-based hospitals and physicians in six areas of the country.

With roots as Uniformed Services Treatment Facilities (USTFs), the USFHP has been a part of the Military Health System for 22 years. Since the DoD reorganized the USTFs in 1993, the USFHP has remained a managed care plan offering all of the health care coverage and benefits, plus some additional enhancements, at the same costs as TRICARE Prime.

When enrolled in the USFHP, members do not access Medicare or MTFs or TRICARE network providers, but instead receive their care from a primary care physician selected by the beneficiary from a network of private physicians affiliated with one of the not-for-profit health care systems offering the plan. That primary care physician assists the member in getting appointments for specialists in the area and coordinates care. Members are covered for worldwide emergency care, many preventive care services, can access on-site patient advocates for assistance, and enjoy enhancements in some areas including discounts for eyeglasses, hearing aids, and dental care.

### Enrollment in the USFHP

To enroll in the USFHP, you must submit a completed application to the USFHP program of choice. Enrollees must reside in the one of the service areas listed below. All eligible beneficiaries may enroll at anytime throughout the year; however, beneficiaries make a one year commitment to receive their care from the plan, unless they move out of the area where the plan is offered. Enrollment fees, if applicable, are portable to another TRICARE Prime program.

USFHP enrollment is offered through:

**Johns Hopkins Community Physicians**
**1-800-808-7347**
*Serving central Maryland and parts of Pennsylvania, Virginia, and West Virginia*

**Martin's Point Health Care**
**1-888-241-4556**
*Serving Maine and New Hampshire*

**Brighton Marine Health Center**
**1-800-818-8589**
*Serving central and eastern Massachusetts, including Cape Cod, and Rhode Island*

**Saint Vincent Catholic Medical Centers**
**1-800-241-4848**
*Serving parts of New York, all of New Jersey, eastern Pennsylvania, and southern Connecticut*

**Christus Health**
**1-800-678-7347**
*Serving southeast Texas and southwest Louisiana*

**Pacific Medical Centers (PacMed Clinics)**
**1-888-958-7347**
*Serving the Puget Sound area of Washington State*

For more information, visit the USFHP Web site at www.usfamilyhealthplan.org.

## TRICARE Overseas

The TRICARE Overseas Program (TOP) is the DoD's managed health care program for all geographic areas and territorial waters outside the 50 United States. TOP blends many of the features of the stateside TRICARE programs while also allowing for the significant cultural differences unique to foreign countries and their health care practices.

The TOP consists of three overseas regions: TRICARE Europe, TRICARE Pacific, and TRICARE Latin America and Canada, which includes the Caribbean Basin. Unlike the three regions in the United States—TRICARE North, TRICARE South, and TRICARE West—the overseas regions are managed by overseas regional directors.

Although TRICARE beneficiaries residing overseas are entitled to the same benefits as those living stateside, several differences in the availability of options exist because of the geographical differences. The benefit packages listed below are available overseas:

**TOP Prime**—Offers TRICARE Prime benefits to active duty service members and their eligible family members residing with their sponsor overseas. There are no enrollment fees, cost-shares, or deductibles for TOP Prime enrollees.

**TOP Standard**—Identical to the stateside program including cost-shares and deductibles. Active duty family members living overseas may choose between TOP Prime and Standard. Retirees and their families who live overseas cannot enroll in TOP Prime but are covered under Standard.

**TOP TRICARE For Life (TFL)**—Available to all beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B. Because Medicare does not provide benefits for medical care received overseas, TFL coverage is similar to TRICARE Standard overseas.

**TRICARE Global Remote Overseas**—Provides access to the TRICARE Prime benefit to active duty service members and family members who are assigned to designated duty stations in remote overseas locations where MTFs are not available. Active duty service members and their families must enroll to a designated remote overseas location.

**Overseas Pharmacy Services**—You may have prescriptions filled at MTF pharmacies in all overseas locations, if the medication is available on the MTF's formulary. TRICARE Mail Order Pharmacy (TMOP) may be used if you have an APO or FPO address or a state department mail pouch for pharmacy. The prescription must be written by a U.S. licensed provider. Drugs purchased by TOP eligible beneficiaries at overseas embassies may not be covered under TRICARE. The TRICARE retail network pharmacy benefit is available overseas only in Puerto Rico, the Virgin Islands, and Guam.

The TRICARE Dental Program (TDP) is also available overseas. For more information about TRICARE benefits available overseas, call 1-888-777-8343. All overseas regions may be reached via this telephone number. You may also visit the TRICARE Web site at www.tricare.osd.mil/overseas for more information.

## Program for Persons with Disabilities

The Program for Persons with Disabilities (PFPWD) will be replaced by the Extended Care Health Option (ECHO) in regional phases over the course of the year 2004. The following information regarding PFPWD pertains to areas where ECHO has not yet become effective.

PFPWD is designed to provide financial assistance to family members of active duty service members in order to treat and/or reduce the effects of mental retardation or serious physical disability. PFPWD is not a stand-alone program and has no enrollment; subject to certain restrictions, it may be used concurrently with other TRICARE medical programs.

The monthly cost-share amount for the PFPWD varies from $25 to $250, depending on the active duty sponsor's rank. PFPWD allowable amounts are not subject to a deductible. The maximum monthly program payment for PFPWD benefits is $1,000. The sponsor is responsible for the appropriate cost-share amount plus any amount in excess of the maximum monthly coverage.

To find out if you or a family member qualifies for the PFPWD, contact Health Net at 1-877-TRICARE (1-877-874-2273).

## Transitional Health Care Benefits

TRICARE offers options for those beneficiaries who are separating from active duty. These options are described below.

### Transitional Assistance Management Program

Through the Transitional Assistance Management Program (TAMP), certain uniformed services members and their family members may be eligible for transitional health care benefits when the sponsor separates from active duty service. Service member categories include:

- A member who is involuntarily separated from active duty
- A Reserve Component member who is separated from active duty and who was called up or ordered in support of a contingency operation for an active duty period of more than 30 consecutive days
- A member who is separated from active duty and is involuntarily retained in support of a contingency operation
- A member who is separated from active duty following a voluntary agreement to stay on active duty for a period of less than one year in support of a contingency mission

### Continued Health Care Benefit Program

The Continued Health Care Benefit Program (CHCBP) is intended to provide transitional benefits for a specified period of time (18–36 months) to former service members and their families, some unremarried former spouses, and emancipated children (living on their own) who enroll and pay quarterly premiums.The benefits available under CHCBP are similar to TRICARE Standard, and although it is not part of TRICARE Standard, it operates under most of the same rules. The quarterly premiums for the coverage are $933 for one person and $1,996 for a family. To receive coverage under CHCBP, eligible persons must enroll by completing a CHCBP application within 60 days after separating from active duty or losing their eligibility for TRICARE. The DoD has contracted with Humana Military Healthcare Services, Inc., (HMHS) to administer CHCBP. Beneficiaries may contact HMHS in writing or by phone for any information regarding CHCBP at the following address or phone number:

Humana Military Healthcare Services, Inc.
Attn: CHCBP
P.O. Box 740072
Louisville, KY 40202
1-800-444-5445

# What TRICARE Covers

TRICARE covers most inpatient and outpatient care that is medically necessary and considered proven. However, there are special rules or limits on certain types of care, while other types of care are not covered at all. Some military treatment facilities (MTFs) may offer services, procedures, or benefits that are not necessarily covered under TRICARE. You should contact your local MTF for more information. To find an MTF near you, visit the MTF Locator on the TRICARE Web site at www.tricare.osd.mil/mtf or visit the Health Net MTF locator at www.healthnetfederalservices.com.

A prior authorization is a process of reviewing medical, surgical, and behavioral health services to ensure medical or psychological necessity and appropriateness of care prior to services being rendered. You or your provider must notify Health Net to obtain a prior authorization. For a complete list of services and/or procedures requiring prior authorization, please see the section entitled, "Beneficiary Tools" or contact Health Net at 1-877-TRICARE (1-877-874-2273).

To find additional information about services covered by TRICARE, contact Health Net, visit their Web site, or visit the TRICARE Web site at www.tricare.osd.mil.

## Emergency and Urgent Care

### Urgent Care

Urgent care services are medically necessary services which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. An urgent care condition could be a sprain, sore throat, or rising temperature. In an urgent situation, you should:

- Go to your Primary Care Manager's (PCM's) office immediately or the next day based on the situation
- Go to a participating specialist with a referral from the PCM coordinated through Health Net
- Go to the emergency room of an MTF hospital (if available) or to a network hospital with a referral from Health Net

### Emergency Services

TRICARE defines an emergency as a medical, maternity, or psychiatric emergency that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition existed, or the absence of medical attention would result in a threat to his/her life, limb, or sight and requires immediate medical treatment, or which has painful symptoms requiring immediate attention to relieve suffering.

In the event of a life-, limb-, or eyesight-threatening emergency, you should go, or be taken to, the nearest emergency department for care. In all emergency situations, you must notify your PCM or regional contractor within 24 hours of any emergency admission so that ongoing care can be coordinated (if enrolled in TRICARE Prime).

## Medical and Surgical Covered Services

The following charts summarize TRICARE-covered services. Any covered services obtained at an MTF are at no cost to you. Please note that TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) offer coverage similar to TRICARE Prime, and if enrolled, you are not responsible for deductibles, cost-shares, or copayments. However, for active duty family members (ADFMs), the waiver of copayments, cost-shares, and deductibles does not apply to pharmacy copayments, Program for Persons with Disabilities (PFPWD) cost-shares, or TRICARE Prime point-of-service (POS) cost-shares and deductibles. See the section entitled "Understanding TRICARE Costs and Fees" for information about the TRICARE Prime POS option. For more information about pharmacy copayments, see the description of the TRICARE Pharmacy Program later in this section.

## Outpatient Services Outside of an MTF

Outpatient services received in an MTF are at no cost to the beneficiary. For the charts on the following pages, "ADFM" is the active duty family member responsibility.

| Services Covered | TRICARE Prime** | TRICARE Extra* | TRICARE Standard* |
|---|---|---|---|
| **Ancillary Services**<br>Certain diagnostic radiology and ultrasound (70000-76999); diagnostic nuclear medicine (78000-78999); pathology and laboratory services (80000-89399); and cardiovascular studies (93000-93350) | Per visit:<br>**ADFM:** No copayment<br><br>**Retirees and others:** No copayment | **ADFM:** 15% of contracted reimbursement<br><br>**Retirees and others:** 20% of contracted reimbursement | **ADFM:** 20% of the maximum allowable charge<br><br>**Retirees and others:** 25% of the maximum allowable charge |
| **Ambulance Services**<br>When medically necessary and when needed for a medical condition that is covered by TRICARE | Per occurrence:<br>**ADFM:** No copayment<br><br>**Retirees and others:** $20 copayment | *Same as above* | *Same as above* |
| **Ambulatory Surgery (Same Day)**(1)<br>When surgery is conducted at a hospital-based or freestanding ambulatory surgical center that is TRICARE-certified<br><br>TRICARE Prime Retirees and others—copayment is applied to the ambulatory surgical facility only. | Per occurrence:<br>**ADFM:** No copayment<br><br>**Retirees and others:** $25 copayment | **ADFM:** $25 copayment<br><br>**Retirees and others:** Professional—20% of contracted reimbursement<br><br>Facility—20% of contracted reimbursement | **ADFM:** $25 copayment<br><br>**Retirees and others:** Professional—25% of the maximum allowable charge<br><br>Facility—25% of the group rate or 25% of billed charges; whichever is less |
| **Durable Medical Equipment (DME), Prosthetic Devices and Medical Supplies (Prescribed by a Physician)**(1)(3)<br>For DME, prosthetic devices, and medical supplies, care is subject to TRICARE policy after an office or home health visit when medically necessary and a covered benefit. | **ADFM:** No copayment<br><br>**Retirees and others:** 20% of contracted reimbursement | **ADFM:** 15% of contracted reimbursement<br><br>**Retirees and others:** 20% of contracted reimbursement | **ADFM:** 20% of the maximum allowable charge<br><br>**Retirees and others:** 25% of the maximum allowable charge |
| **Emergency Services**(1)<br>Emergency care obtained on an outpatient basis, both network and non-network, in or out of the region. | Per visit:<br>**ADFM:** No copayment<br><br>**Retirees and others:** $30 copayment | *Same as above* | *Same as above* |

**Cost-share is applied after deductible has been satisfied.*

***Benefits under TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are similar to TRICARE Prime*

1. *TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.*
2. *If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.*
3. *Requires prior authorization for TRICARE Prime, TPR, and TPRADFM, depending on the item or amount billed.*

## Outpatient Services Outside of an MTF (continued)

| Services Covered | TRICARE Prime** | TRICARE Extra* | TRICARE Standard* |
|---|---|---|---|
| **Eye Examinations**<br>One routine examination per year for active duty family members. For additional coverage, see "Eye Examinations" under Clinical Preventive Services Benefits. | **ADFM:**<br>No copayment<br><br>**Retirees and others:**<br>Not covered | **ADFM:** 15% of contracted reimbursement<br><br>**Retirees and others:**<br>Not covered | **ADFM:** 20% of the maximum allowable charge<br><br>**Retirees and others:**<br>Not covered |
| **Individual Provider Services**[1]<br>Office visits; outpatient office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services, e.g., physical therapy, speech pathology services, and occupational therapy; medical supplies used within the office, including casts, dressings, and splints. | Per visit:<br>**ADFM:**<br>No copayment<br><br>**Retirees and others:**<br>$12 copayment | **ADFM:** 15% of contracted reimbursement<br><br>**Retirees and others:**<br>20% of contracted reimbursement | **ADFM:** 20% of the maximum allowable charge<br><br>**Retirees and others:**<br>25% of the maximum allowable charge |
| **Immunizations for Required Overseas Travel**<br>Immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations. | Per Visit:<br>**ADFM:** No copayment<br><br>**Retirees and others:**<br>Not covered | **ADFM:** 15% of contracted reimbursement<br><br>**Retirees and others:**<br>Not covered | **ADFM:** 20% of the maximum allowable charge<br><br>**Retirees and others:**<br>Not covered |
| **Laboratory and X-Ray Services (provided as part of an office visit)** [1][2]<br>TRICARE Prime retirees and others do not have an additional copayment if these services are provided as part of an office visit. | Per visit:<br>**ADFM:**<br>No copayment<br><br>**Retirees and others:**<br>$12 copayment | **ADFM:** 15% of contracted reimbursement<br><br>**Retirees and others:**<br>20% of contracted reimbursement | **ADFM:** 20% of the maximum allowable charge<br><br>**Retirees and others:**<br>25% of the maximum allowable charge |

**Cost-share is applied after deductible has been satisfied.*

***Benefits under TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are similar to TRICARE Prime*

1. *TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.*
2. *If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.*
3. *Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.*

## Home Health Care

Same as the Medicare home health care benefit, providing a maximum of 28 hours per week part-time, or 35 hours per week intermittent, skilled nursing care and physical, speech, and occupational therapy. All care must be provided by a participating home health care agency.

Services provided by an authorized home health care agency that are covered under the Home Health Prospective Payment System (PPS) do not have a beneficiary copayment or cost-share. Other services provided outside of the PPS may be subject to a copayment or cost-share.

## Inpatient Services (Both MTF and Civilian Facility)*

| Services Covered | TRICARE Prime** | TRICARE Extra | TRICARE Standard |
|---|---|---|---|
| **Hospitalization**[1][2][3]<br>Semiprivate room (and, when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and surgical services; meals (including special diets); drugs and medications while an inpatient; operating and recovery room; anesthesia; laboratory tests; X-rays and other radiology services; necessary medical supplies and appliances; and blood and blood products. Unlimited services, as medically necessary. | **ADFM:**<br>MTF: No copayment<br>Civilian: No copayment<br><br>**Retirees and others:**<br>MTF: $13.32 per day<br>Civilian: $11 per day or $25 minimum charge per admission, whichever is greater.<br><br>(No separate copayment for separately billed professional charges. Catastrophic Cap protection limits do apply.) | **ADFM:**<br>MTF: $13.32 per day<br>Civilian: $13.32 per day or $25 minimum charge per admission, whichever is greater.<br><br>**Retirees and others:**<br>MTF: $13.32 per day<br>Civilian: $250 per day or 25% cost-share of the total contracted reimbursement for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges based on the contracted reimbursement. | **ADFM:**<br>MTF: $13.32 per day<br>Civilian care: $13.32 per day or $25 minimum charge per admission, whichever is greater.<br><br>**Retirees and others:**<br>MTF: $13.32 per day<br>Civilian: $459 per day or 25% cost-share of billed charges, whichever is less, plus 25% cost-share of the maximum allowable charge for separately billed professional charges. |
| **Maternity**[1][2]<br>Hospital and professional services (prenatal, postnatal). Unlimited services, as medically necessary. | *Same as above* | *Same as above* | *Same as above* |
| **Skilled Nursing Facility (SNF) Care**[1][4]<br>Semiprivate room; regular nursing services; meals including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances. Unlimited services, as medically necessary. | *Same as above* | **ADFM:**<br>MTF: $13.32 per day<br>Civilian: $13.32 per day or $25 minimum charge per admission, whichever is greater.<br><br>**Retirees and others:**<br>MTF: $13.32 per day<br>Civilian: Lesser of $250 per day or 20% of the negotiated fee for institutional services, plus 20% of the negotiated professional fee. | **ADFM:** $25 per admission or $13.32 per day, whichever is greater.<br><br>**Retirees and others:**<br>25% cost-share of allowed charges, plus 25% cost-share of the maximum allowable charge for separately billed professional charges. |

** Cost-shares reflecting a dollar amount are subject to change (i.e. $13.32 per day).*
*** Benefits under TPR and TPRADFM are similar to TRICARE Prime.*
*1. Cost-share and daily inpatient charges are subject to change at the beginning of each fiscal year (October 1–September 30).*
*2. TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.*
*3. TRICARE Standard cost-shares for retirees may vary depending on type of treatment or type of hospital.*
*4. Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.*

## Hospice Care

Hospice care is available, in lieu of other TRICARE benefits, to provide palliative care to individuals with prognoses of less than six months to live if the terminal illness runs its normal course. Hospice care must be provided by a Medicare-approved program and may include: physician services, nursing care, counseling, inpatient respite care, medical supplies, medications, medical social services, home health aide services, physical and occupational services, speech and language pathology, and short-term acute patient care related to terminal diagnosis.

**Note:** The individual hospice may charge a cost-share for medications, biologicals, and/or inpatient respite care.

## Clinical Preventive Services

| Service | TRICARE Prime* | TRICARE Extra | TRICARE Standard |
|---|---|---|---|
| **Clinical Preventive Examinations**<br>Comprehensive-health-promotion and disease-prevention exams for ages 24 months and older.<br><br>Examinations can include: blood pressure tests; clinical breast exams (high-risk women age 39 and under; annually for all women over 40); pelvic exams (same guideline as Pap smears and should be administered during same visit); clinical testicular exams (annually for high-risk men 13-39); digital rectal exams (annually for high-risk men 40-49; and all men over 50); Prostate Specific Antigen (annually for high-risk men 40-49; men with history of vasectomy at least 20 years previous or at age 40 and over; and all men over 50); oral cavity exams; thyroid palpations; school enrollment physicals ages 5-11 years.<br><br>***Note**: Annual sports physicals are not a covered benefit under TRICARE.* | No copayment<br><br>*Clinical preventive services are an enhanced benefit under TRICARE Prime.* | Applicable cost-share and deductible apply. | Applicable cost-share and deductible apply. |
| **Eye Examinations**<br>Clinical preventive service eye exams vary by TRICARE program option (see columns for details of coverage for children and adults).<br><br>***Note:** In addition to the clinical preventive service eye exams, ADFMs can receive annual eye exams under normal TRICARE outpatient benefits.*<br><br>Except for active duty service members (ADSMs), lenses or eyeglasses are only cost-shared for treatment of infantile glaucoma, keratoconus, dry eyes, and irregularities in the shape of the eye. | ***For Infants:***<br>**No copayment**<br>• One eye and vision screening by the beneficiary's PCM during routine exam at birth and 6 months of age. Exam to include screening for visual acuity, ocular alignment, and red reflex along with external examination for ocular abnormalities.<br>***For Adults and Children Age 3 and over:***<br>**No copayment**<br>• One comprehensive eye exam by a specialist (ophthalmologist or optometrist) including screening for visual acuity and glaucoma every two years.<br>• Diabetic patients at any age are covered for one comprehensive eye exam yearly. | ***For Children:***<br>**Covered under Well-Child Care benefit.**<br>Applicable cost-share and deductible apply.<br>• One eye and vision screening by a TRICARE network provider during routine exam at birth and 6 months of age.<br>• Two comprehensive eye exams by specialist (ophthalmologist or optometrist) for amblyopia (vision loss) and strabismus (cross eye) between 3-6 years of age.<br>***For Adults:***<br>Not covered | ***For Children:***<br>**Covered under Well-Child Care benefit.**<br>Applicable cost-share and deductible apply.<br>• One eye and vision screening by a TRICARE network provider during routine exam at birth and 6 months of age.<br>• Two comprehensive eye exams by specialist (ophthalmologist or optometrist) for amblyopia (vision loss) and strabismus (cross eye) between 3-6 years of age.<br>***For Adults:***<br>Not covered |

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

## Clinical Preventive Services (continued)

| Service | TRICARE Prime* | TRICARE Extra | TRICARE Standard |
|---|---|---|---|
| **Immunizations**<br>Age appropriate doses of vaccines recommended and adopted by the Center for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). Refer to CDC's homepage (www.cdc.gov) for a current schedule of recommended vaccines.<br><br>*Immunizations for Overseas Travel: See information listed in the Outpatient Services Outside of the MTF section of these charts.* | No copayment | Applicable cost-share and deductible apply. | Applicable cost-share and deductible apply. |
| **Patient and Parent Education or Counseling Services**<br>The following education or counseling services are covered when included as part of an office visit: dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; accident and injury prevention; promoting dental health; stress, bereavement, and suicide risk assessment. | No copayment | Applicable cost-share and deductible apply. | Applicable cost-share and deductible apply. |
| **Periodic Screening Examinations**<br>Beneficiaries will be offered age- and gender-appropriate screening tests for the early detection of disease and/or disease risk factors, including:<br><br>**Cancer Screening:** Annual screening mammograms for women over the age of 39, (for high-risk baseline at 35 years, then annually); Pap smears (see below); proctosigmoidoscopy or sigmoidoscopy (once every 3-5 years beginning at age 50); colonoscopy (every 2 years beginning at age 25 or 5 years younger than the earliest age of diagnosis for colon rectal cancer, whichever is earlier, and then annually after age 40 for individuals with hereditary non-polyposis colon rectal cancer syndrome. Individuals with familial risk of sporadic colon rectal cancer (i.e., individuals with first degree relatives with sporadic colon rectal cancer or adenomas before the age of 60 or multiple first degree relatives with colon rectal cancer or adenomas) may receive a colonoscopy every 3 to 5 years beginning at age 10 years earlier than the youngest affected relative), and fecal occult blood testing (annually age 50 and above); skin cancer exams (for high-risk individuals with family history or increased exposure to sunlight) | No copayment | Applicable cost-share and deductible apply. | Applicable cost-share and deductible apply. |

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

## Clinical Preventive Services (continued)

| Service | TRICARE Prime* | TRICARE Extra | TRICARE Standard |
|---|---|---|---|
| **Routine Pap Smears:** Annually starting at age 18 (or younger if sexually active) until three consecutive satisfactorily normal annual examinations. Frequency may be less often at the discretion of the patient and the clinician, but not less than every three years.<br><br>**Infectious Disease Screening:** Screening for Hepatitis B, Rubella antibodies, and HIV and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, Hepatitis A&B, meningococcal meningitis, and tuberculosis<br><br>**Cardiovascular:** Cholesterol (once every 5 years beginning at age 18) and blood pressure (children: annually between ages 3-6 and every 2 years thereafter; adults: minimum every 2 years)<br><br>**Hearing:** Preventive hearing screenings for all high risk neonates as defined by the Joint Committee on Infant Hearing. A newborn audiology screening should be performed on high-risk newborns prior to hospital discharge or within the first three months. Evaluative hearing tests may be performed at other ages during routine exams.<br><br>**Other:** Assessment of risk for lead exposure by structured questionnaire (during each Well-Child Care visit from 6 months to 6 years); blood lead test for all children determined to be high-risk | No copayment | Applicable cost-share and deductible apply. | Applicable cost-share and deductible apply. |
| **Well-Child Care**<br>Well-Child Care (birth to 6 years) includes routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight, and head circumference; routine immunizations; and developmental and behavioral appraisal in accordance with the American Academy of Pediatrics (AAP) and CDC guidelines. | No copayment | Applicable cost-share and deductible apply. | Applicable cost-share and deductible apply. |

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

For the services listed in the preceding charts, TRICARE has established catastrophic caps (cat caps). Cat caps act as built-in safety nets to limit beneficiaries' out-of-pocket expenses on TRICARE-covered medical bills. In order to get medical costs credited toward cat caps, the beneficiary may be required to provide proof of medical care, such as an explanation of benefits (EOB). Please see the section entitled, "Understanding TRICARE Costs and Fees" for information about catastrophic caps.

### Hepatitis B Screening and Vaccines

For Hepatitis B Surface Antigen (HBsAg):

- Screenings for pregnant women during prenatal period.
- Infants born to HBsAg-negative mothers receive Hepatitis B vaccine as recommended by the American Academy of Pediatrics (AAP).
- Infants born to HBsAg-positive mothers receive Hepatitis B Immune Globulin (HBIG) as recommended by the American Academy of Pediatrics.

High-risk adults and children receive Hepatitis B vaccine as recommended by the Center for Disease Control Advisory Committee on Immunization Practices. There is no copayment for TRICARE Prime. Applicable cost-share and deductible apply for TRICARE Extra and TRICARE Standard when the service is included as part of a cancer screening visit.

## Maternity Care

TRICARE helps pay for maternity care during pregnancy, delivery of the baby, and up to six weeks after the baby is born. Prenatal care is important, and TRICARE strongly recommends that those who are pregnant, or who anticipate becoming pregnant, seek appropriate medical care. If TRICARE eligibility ends during the pregnancy (for example, due to discharge of sponsor), TRICARE does not cover any remaining maternity care unless the family qualifies for the Transitional Assistance Management Program (TAMP) or has enrolled in the Continued Health Care Benefits Program (CHCBP).

### Family-Centered Care

The new family-centered care program offers families services starting with the first obstetric (OB) visit and continuing after the birth of the child. In creating the family-centered care program, the military services combine their expertise to offer patients a world-class OB benefit while upholding the military's unique ability to assist family members whose sponsors are deployed. Family-centered care gives you:

- Respect for your emotional well-being, privacy, and personal preferences
- Empowerment through honoring your family's personal and cultural beliefs
- Choices in treatment, including pain management, drugs, and tests used before, during, and after childbirth and newborn care
- Flexibility to welcome fathers, significant others, and siblings to be a part of your childbirth experience

Your local MTFs are committed to being responsive to your needs and have implemented several initiatives that include:

- Improved continuity of providers for prenatal care
- Careful, seamless coordination between facilities if you need to relocate during your pregnancy
- Personalized pain management
- Individualized birth plans
- Improved access to first trimester appointments
- Individualized prenatal education
- Private post partum rooms
- Lactation education and support

Some facilities have even instituted "stork parking" and allow you to schedule follow up appointments before you leave the clinic. Before checking into the civilian network for maternity care and delivery options, we encourage you to visit your local MTF. Military facilities offer an extended "family" who understand the uniqueness of military life.

## Behavioral Health Care Services

ADFM represents the active duty family member responsibility.

| Services | TRICARE Prime | TRICARE Extra | TRICARE Standard |
|---|---|---|---|
| **Outpatient Behavioral Health**[1][2][5] Outpatient psychotherapy is limited to a maximum of two psychotherapy sessions per week in any combination of individual, family, collateral, or group sessions. | Individual & Family Therapy: **ADFM:** No copayment<br>**Retirees and others:** $25 copayment<br>Group Therapy: **ADFM:** No copayment<br>**Retirees and others:** $17 copayment | Cost-share after deductible has been satisfied:<br>**ADFM:** 15% of contracted reimbursement<br>**Retirees and others**: 20% of contracted reimbursement | Cost-share after deductible has been satisfied:<br>**ADFM:** 20% of the TRICARE-allowed amount<br>**Retirees and others:** 25% of the TRICARE-allowed amount |
| **Medication Management** No prior authorization is required. (CPT code 90862) | **ADFM:** No copayment<br>**Retirees and others:** $12 copayment | *Same as above* | *Same as above* |
| **Hospitalization for Mental Illness**[1][2][3][4] Up to 30 days per fiscal year (October 1–September 30) for age 19 and over; up to 45 days per fiscal year for age 18 and under. The Residential Treatment Center benefit is up to 150 days per fiscal year for children and adolescents (as medically or psychologically necessary). | **ADFM:** No copayment<br>**Retirees and others:** $40 per day (No copayment for separately billed professional charges.) | **ADFM:** $20 per day ($25 minimum charge)<br>**Retirees and others:** 20% cost-share of contracted reimbursement for institutional services, plus 20% cost-share of separately billed professional charges, based on contracted reimbursement. | **ADFM:** $20 per day ($25 minimum charge)<br>**Retirees and others:** 25% cost-share of allowable charges for separately billed professional charges, plus, one of the following:<br>Inpatient High Volume Hospital: 25% hospital specific per diem<br>Inpatient Low Volume Hospital: The lesser of $164 per day or 25% hospital specific per diem<br>RTC: 25% of the TRICARE-allowed amount<br>Partial Hospitalization: 25% of the TRICARE-allowed amount |
| **Substance Use Treatment (Inpatient Partial Hospital Program)**[1][2][3][4] Up to seven days for detoxification and up to 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward inpatient day limit. | *Same as above* | *Same as above* | *Same as above* |
| **Partial Hospitalization—Mental Illness**[1][2][3] Up to 60 days per fiscal year (October 1–September 30). Minimum of three hours per day, five days per week of therapeutic services. | *Same as above* | *Same as above* | *Same as above* |

*1. Requires prior authorization.*

*2. TRICARE Standard beneficiaries may have to pay up to 15 percent over the maximum allowable charge when the provider does not accept assignment (balance billing). Treatment must be provided by TRICARE-authorized institutional providers.*

*3. Cost-share and daily inpatient charges are subject to change at the beginning of each fiscal year (October 1–September 30).*

*4. NAS **Note:** A nonavailability statement (NAS) is required for all nonemergency inpatient admissions with TRICARE Extra and TRICARE Standard. This does not apply to admissions to RTC, PHP, and SUDRF facilities.*

*5. All services provided by Pastoral Counselors or Licensed Professional Counselors (LPCs) must be referred and supervised by a physician (M.D. or D.O.).*

### Getting Behavioral Health Care

Health Net manages the behavioral health benefit and MHN, Inc. (MHN) manages the network of behavioral health care providers. You are encouraged to receive behavioral health care from an MTF. However, access may be limited due to space-availability issues or the MTF's ability to render the care needed. When a service is not available at an MTF, you may seek behavioral health care from a network provider. Before you do, please check with your PCM or Health Net to make sure you have all required referrals and authorizations. This will ensure you receive the correct benefit payment.

## TRICARE Pharmacy Program

TRICARE provides a world-class pharmacy benefit. TRICARE beneficiaries, including Medicare-eligible beneficiaries age 65 and over, are eligible for the TRICARE Pharmacy Program and can fill prescription medications at MTF pharmacies, through the TRICARE Mail Order Pharmacy (TMOP), and at retail network and non-network pharmacies. To have a prescription filled, you will need a written prescription and a valid uniformed services ID card. If you are Medicare-eligible and turned age 65 on April 1, 2001, or later, you must be enrolled in Medicare Part B.

### Generic Drug Use Policy

It is the Department of Defense's (DoD's) policy to substitute generic medications for brand-name medications when available. Brand-name drugs that have a generic equivalent may be dispensed only if the prescribing physician is able to justify medical necessity for use of the brand-name drug in place of the generic equivalent. If a generic equivalent drug does not exist, the brand-name drug will be dispensed at the brand-name copayment.

### Drug/Medication Coverage

The DoD Pharmacy and Therapeutics Committee has established quantity limits on certain medications, which means that DoD will pay only for up to a specified quantity per 30-, 60-, or 90-day supply. Quantity limits are applied to address the problem of overuse of medications that can be unsafe for you and costly to the government. Exceptions to established quantity limits can be made if the prescribing physician is able to justify medical necessity. Additionally, some drugs require prior authorization. For a general list of prescription drugs that are covered under TRICARE and for drugs requiring prior authorization or quantity limits at TRICARE retail network pharmacies, visit www.express-scripts.com/TRICARE or call toll-free at 1-866-DoD-TRRx (1-866-363-8779).

### TRICARE Pharmacy Options

#### MTF Pharmacies

Prescriptions may be filled (up to a 90-day supply for most medications) at an MTF pharmacy free of charge. Each facility is required to make available the medications listed in the DoD basic core formulary. The MTF may add additional medications to its local formulary based on the scope of care at that MTF. Beneficiaries should contact their local MTF for specific details about filling and refilling prescriptions at its pharmacy. MTF pharmacies will accept written prescriptions from any TRICARE-authorized provider. MTF pharmacies will fill prescriptions from civilian providers as long as they are approved by the MTF (formulary) for distribution and are not restricted.

#### TRICARE Mail Order Pharmacy

The TRICARE Mail Order Pharmacy (TMOP) is available for prescriptions that you take on a regular basis. You may receive up to a 90-day supply for most medications. TMOP is administered by Express Scripts, Inc. TMOP allows you to mail your written prescription, along with the appropriate copay, to TMOP, and the medications will be sent directly to you. Prescriptions may be refilled by mail, phone, or online. For more information about how to use TMOP, visit the TRICARE Web site at www.tricare.osd.mil/pharmacy/tmop.cfm or contact TMOP member services toll-free at 1-866-DoD-TMOP (1-866-363-8667) within the U.S., or 1-866-ASK-4PEC (1-866-275-4732) outside the U.S. You may also visit the Express Scripts Web site at www.express-scripts.com/TRICARE.

## TRICARE Retail Pharmacy Network

You may have prescriptions filled at any civilian retail network pharmacy for a small copayment. The TRICARE Retail Pharmacy Network is administered by Express Scripts, Inc. For more information or to locate a TRICARE network pharmacy near you, contact Express Scripts at www.express-scripts.com/TRICARE or 1-866-DoD-TRRx (1-866-363-8779).

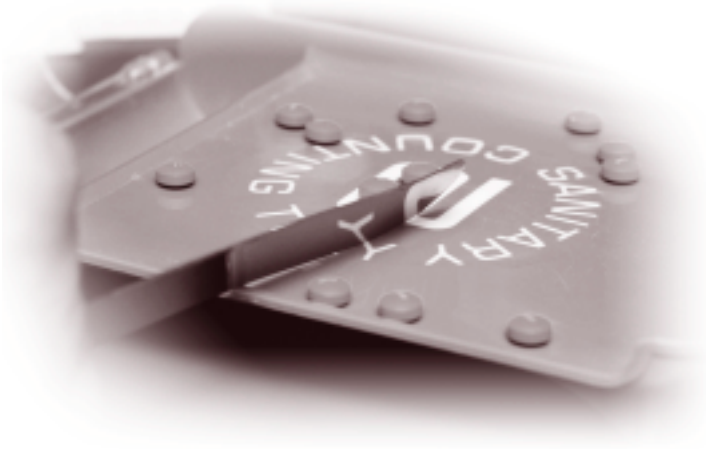
## Non-network Pharmacies

Filling prescriptions at a non-network pharmacy is the most expensive option and is not recommended. You may have to pay for the total amount first and file a claim to receive a partial reimbursement.

## Pharmacy Copayments

| Place of Service | Generic | Brand Name |
|---|---|---|
| MTF Pharmacy | $0 | $0 |
| TMOP (up to a 90-day supply) | $3 | $9* |
| Retail Network Pharmacy (up to a 30-day supply) | $3 | $9* |
| Non-network Pharmacy | 1. $9* or 20% of total cost (whichever is greater)<br><br>2. Existing deductibles and point-of-service** (POS) penalty apply: E-4 and below, TRICARE Standard, $50 per person/$100 per family; E-5 and above, TRICARE Standard, $150 per person/$300 per family; TRICARE Prime, $300 per person/$600 per family, POS penalty–50%. | |

**Some prescriptions may be classified as "non-formulary." In these cases, you will be responsible for a $22 cost-share with TMOP or in the TRICARE Retail Pharmacy Network. In non-network pharmacies, you will be responsible for a $22 cost-share or 20 percent, whichever is higher.*
***Please see the description of point-of-service (POS) in the section entitled "Understanding TRICARE Costs and Fees."*




## Pharmacy Data Transaction Service

The Pharmacy Data Transaction Service (PDTS) creates a global centralized data repository that records information about prescriptions filled for TRICARE beneficiaries at MTFs, the TRICARE retail pharmacy network, and through TMOP. PDTS improves the quality of prescription services and enhances patient safety by conducting an online clinical screening against your complete medication history for each new or refilled prescription in real time before it is dispensed.

# Limitations and Exclusions

Below you will find a list of medical, surgical, and behavioral health care services generally not covered under TRICARE. The items here are not intended to be all-inclusive. Contact Health Net, visit their Web site at www.healthnetfederalservices.com, or visit the TRICARE Web site at www.tricare.osd.mil for more information.

## Services or Procedures with Significant Limitations

**Abortions**—Abortions are only covered when the mother's life is in danger. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.

**Cardiac and Pulmonary Rehabilitation**—Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.

**Chiropractic Care**—Coverage is limited to active duty service members and is only available at specific military treatment facilities under the Chiropractic Care Program. Visit the TRICARE Web site at www.tricare.osd.mil/chiropractic for more information.

**Cosmetic, Plastic, or Reconstructive Surgery**—Only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement, or after a medically necessary mastectomy.

**Cranial Orthotic Device or Molding Helmet**—Cranial orthotic devices are excluded for treatment of nonsynostic positional plagiocephaly.

**Dental Care and Dental X-Rays**—Both are covered only for adjunctive dental care.

**Dental Anesthesia and Facility Charges**—Covered only to safeguard a patient's life.

**Education and Training**—Education and training may be covered under the PFPWD. Outpatient diabetic self-management and training programs are covered when the services are provided by a TRICARE authorized individual provider who also meets national standards for diabetes self-management education programs recognized by the American Diabetes Association (ADA). The provider's "Certificate of Recognition" from the ADA must accompany the claim for reimbursement.

**Eyeglasses or Contact Lenses**—Both are covered under limited circumstances such as corneal lens removal.

**Food, Food Substitutes or Supplements, or Vitamins**—Not covered outside of a hospital setting.

**Gastric Bypass**—To be covered, you must be 100 pounds over ideal body weight and have a co-morbidity or 200 percent of ideal body weight with no co-morbidity.

**Genetic Testing**—Genetic testing is only covered under certain conditions.

**Hearing Aids**—Hearing aids are covered under the PFPWD.

**Intelligence Testing**—Only covered when medically necessary for the diagnosis or treatment planning of covered psychiatric disorders.

**Marital Therapy and/or Couples Counseling**—Beneficiaries for whom this treatment is authorized must have a covered DSM-IV primary diagnosis, and the marital or couples therapy must be medically necessary.

**Private Hospital Rooms**—Not covered unless ordered for medical reasons, or a semi-private room is not available. Hospitals that are subject to the TRICARE diagnosis-related group (DRG) payment system may provide the patient with a private room, but will only receive the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.

**Smoking Cessation**—Not a covered service except for certain TRICARE Prime Remote active duty service members who meet specific criteria.

**Weight Reduction**—Only covered when psychiatric or psychological evaluations are conducted to assess appropriateness for covered surgical gastric procedures.

## Exclusions

The following services are excluded under any circumstance:

- Acupuncture
- Artificial insemination
- Autopsy services or post-mortem examinations
- Care that is not medically or psychologically necessary
- Birth control (non-prescription)
- Camps
- Care or supplies furnished or prescribed by an immediate family member
- Diagnostic admissions
- Experimental or unproven procedures
- Foot care (routine)
- Laser/LASIK/Refractive corneal surgery
- Learning disabilities
- Megavitamins and orthomolecular psychiatric therapy
- Mind expansion and elective psychotherapy
- Naturopaths
- Psychiatric treatment for sexual dysfunction
- Sex changes or sexual inadequacy treatment
- Telephone counseling consultation

# Understanding TRICARE Costs and Fees

Review the benefits and coverage charts in the section entitled, "What TRICARE Covers" for more information about specific cost-shares and copayments for TRICARE-covered services.

## TRICARE Annual Deductible

There is no annual deductible for TRICARE Prime or TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM). (However, there is a deductible if a TRICARE Prime or TPRADFM beneficiary exercises the point-of-service [POS] option.)

TRICARE Extra and TRICARE Standard beneficiaries are required to meet an annual deductible for outpatient services. The deductibles are as follows:

- ADFMs E-4 and below: $50/person or $100/family per fiscal year
- All retirees and active duty family members E-5 and above: $150/person or $300/family per fiscal year

## TRICARE Prime Point-of-Service Option

The TRICARE Prime POS option applies to all non-referred, nonemergency services received by TRICARE Prime and TPRADFM beneficiaries. The POS deductible applies only to outpatient services, and the cost-share applies to both inpatient and outpatient services. TRICARE reimbursement is limited to 50 percent of the TRICARE allowable charge. The POS option also applies to prescription drugs. If you take your prescription into a non-network pharmacy, you will pay more. POS cost-sharing and deductible amounts do not apply if you have OHI. The POS deductibles and cost-shares are as follows (for all beneficiary categories):

| | |
|---|---|
| Deductibles: | $300 per individual/$600 per family |
| Cost-share: | 50 percent of the TRICARE allowable charge |

## Catastrophic Cap Benefit

The catastrophic cap limits your out-of-pocket liability on copayments, cost-shares, and deductibles. The catastrophic cap by beneficiary category is as follows:

- ADFMs using TRICARE Standard—$1,000 per fiscal year
- All other beneficiaries using TRICARE Standard (retirees, family members of retirees, survivors, former spouses)—$3,000 per fiscal year
- ADFMs using TRICARE Prime—$1,000 per family, per fiscal year
- All other beneficiaries using TRICARE Prime (retirees, family members of retirees, survivors, former spouses)—$3,000 per family, per fiscal year

### TRICARE Prime POS Option and the Catastrophic Cap

For unauthorized care, the TRICARE Prime POS deductible is $300 per person and $600 per family. The beneficiary cost-share is 50 percent of the allowable charges after the deductible.

The TRICARE Prime beneficiary's out-of-pocket cost while utilizing POS is accrued against the catastrophic cap. However, there is no cap on POS out-of-pocket expenses. The beneficiary cost-share will remain at 50 percent of the TRICARE allowable charge even after the catastrophic cap has been reached.

## Other Health Insurance

TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs/plans as identified by the TRICARE Management Activity (TMA). If you have other health insurance (OHI), you are not required to obtain referrals or authorizations for covered services, except for those that require prior authorization. A former spouse covered by an employer-sponsored OHI plan is not eligible for TRICARE.

Please inform your provider and Health Net if you have OHI so that your benefits can be coordinated and so there is no delay in payment of claims.

## Third Party Liability

The Federal Medical Recovery Act allows TRICARE to be reimbursed for its costs of treating you if you are injured in an accident that was caused by someone else. The DD Form 2527 Statement of Personal Injury Third Party Liability Form will be sent to you if a claim is received that appears to have third party liability involvement. Within 35 calendar days, you must complete and sign this form and follow the directions for returning the form to the appropriate claims processor. The DD Form 2527 is available through the Health Net Web site at www.healthnetfederalservices.com.

## TRICARE Explanation of Benefits

A TRICARE explanation of benefits (EOB) is a statement sent to you showing what action has been taken on your TRICARE claims. An EOB is sent to you for your information and files. An EOB is not a bill. After reviewing the EOB, you have the right to appeal certain decisions regarding your claims and must do so in writing within 90 days of the date of the EOB notice. You should keep EOBs with your health insurance records for reference.

# Your TRICARE Claims

If you receive services from a military treatment facility (MTF) or network provider, you will not be required to submit your own claims. TRICARE Standard beneficiaries who receive services from a TRICARE-authorized, non-network provider may be required to submit their own claims. These beneficiaries can access the Health Net Web site at www.healthnetfederalservices.com for instructions on how to submit claims or call 1-877-TRICARE (1-877-874-2273) for TRICARE claims assistance.

If you need to file your own TRICARE claim, send the claim to the following address:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE
P.O. Box 870140
Surfside Beach, SC 29587-9740

## Claims for Active Duty Service Members

All claims for active duty service members must be submitted to Health Net/PGBA for processing and payment and should be submitted to the following address:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE
P.O. Box 870140
Surfside Beach, SC 29587-9740

## Claims for Dual-Eligible Beneficiaries (Medicare and TRICARE)

Wisconsin Physicians Service (WPS) is the claims processor for all claims for beneficiaries who are eligible for both TRICARE and Medicare. Claims are submitted on your behalf by your provider and you will receive an explanation of benefits (EOB) from WPS after the claims processing has been completed. The following chart contains important contact information for you regarding dual-eligible claims.

| | |
|---|---|
| Claims Submission | WPS TRICARE For Life<br>P.O. Box 7890<br>Madison, WI 53707-7890 |
| Appeals | WPS TRICARE For Life<br>Attn: Appeals<br>P.O. Box 7490<br>Madison, WI 53707-7490 |
| Program Integrity | WPS TRICARE For Life<br>Attn: Program Integrity<br>P.O. Box 7516<br>Madison, WI 53707-7516 |
| Third Party Liability | WPS TRICARE For Life<br>Attn: Third Party Liability<br>P.O. Box 7897<br>Madison, WI 53707-7897 |
| Refunds | WPS TRICARE For Life<br>Attn: Refunds<br>P.O. Box 7928<br>Madison, WI 53707-7928 |
| Customer Service | WPS TRICARE For Life<br>P.O. Box 7889<br>Madison, WI 53707-7889 |
| Toll-free | 1-866-773-0404 |
| Toll-free TDD Telephone | 1-866-773-0405 |
| Online | www.tricare4u.com |

## Submitting Claims While Transitioning to the TRICARE North Region

As the current TRICARE regions transition to the new TRICARE North Region, it is important that you and/or your provider pay careful attention to the dates of service, the current region in which you are receiving care, and the transition dates in order to file with the correct claims processor. The regions and transition dates are described below.

### Virginia, North Carolina, West Virginia, Kentucky, Tennessee (Ft. Campbell area), Ohio, Indiana, Illinois, Missouri (St. Louis area), Iowa (Rock Island Arsenal area), Wisconsin, and Michigan

All TRICARE claims with dates of service prior to or on June 30, 2004, should continue to be sent to Humana Military/PGBA. You must submit all claims within 60 days of the date that care was provided or the date the primary payer has made payment or denied the claim. Your cooperation will assure that Humana Military processes your claims efficiently and accurately.

All claims with dates of service on July 1, 2004, or after should be sent to the following address:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE
P.O. Box 870140
Surfside Beach, SC 29587-9740

### Maine, New Hampshire, Vermont, New York, Pennsylvania, New Jersey, Connecticut, Rhode Island, Massachusetts, Delaware, Maryland, and the District of Columbia

All TRICARE claims with dates of service prior to or on August 31, 2004, should continue to be sent to Sierra Military Health Services/PGBA. You must submit all claims within 60 days of the date that care was provided or the date the primary payer has made payment or denied the claim. Your cooperation will assure that Sierra processes your claims efficiently and accurately.

All claims with dates of service on September 1, 2004, or after should be sent to the following address:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE
P.O. Box 870140
Surfside Beach, SC 29587-9740

If you need assistance with filing a claim or have questions, please call Health Net at 1-877-TRICARE (1-877-874-2273).

# Ensuring Customer Satisfaction

## Appealing a Decision

If you believe a service or claim was improperly denied, in whole or in part, you (or another appropriate party) may file an appeal. A proper appealing party may include: TRICARE participating provider(s) who are not network providers but accept TRICARE assignment, parents or legal guardians of minors, or a formally appointed representative of the beneficiary.

There are two types of appeals:

- Your claim has been denied—For example, your claim is paid under the TRICARE Prime point-of-service (POS) option, but you believe it was an emergency and should have been paid under TRICARE Prime, or payment for services was denied because it was not a covered benefit or medically necessary.
- Your prior authorization for care has been denied—You or your provider request prior authorization for medical care, and it is denied.

### Claim Appeals

Claim appeals can involve a full or partial denial of a claim. If you believe your claim was improperly denied, you may file an appeal. The appeal must be in writing and filed within 90 calendar days of the date of the explanation of benefits (EOB). You will receive a reply from Health Net within 30 days of receipt of your appeal. Claim appeals must include the following information:

- The patient's name, address, phone number, and sponsor's social security number
- An explanation of the reason for the disagreement
- Printed name and signature of the patient or proper appealing party
- A copy of the Health Net denial notification letter with the request

The following information is suggested in the appeals process, but not required:

- The word "appeal" in the first paragraph of the request
- The reason for the appeal, including the dollar amount being questioned
- A copy of the EOB, and any other documents related to the issue

Mail claim appeals to:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE Claim Appeals
P.O. Box 870148
Surfside Beach, SC 29587-9748

### Request for Prior Authorization Denials

A prior authorization is the formal approval required by Health Net before you may obtain a TRICARE covered service. In some cases, Health Net may deny prior authorizations if:

- It is determined that the requested service could be provided at another level of care (a doctor's office rather than a hospital).
- It is determined that the service is not medically necessary or not a TRICARE benefit.
- You are an inpatient at a medical facility and an extended stay has been denied.

Prior authorization denial appeals may be either expedited or non-expedited, depending on the urgency of the situation. An *expedited* review of a prior authorization denial must be filed by you or an appointed representative within three calendar days after receipt of the initial denial. Health Net will issue a determination letter no later than three working days after your request for review is received.

A *non-expedited* review of a denial must be filed no later than 90 days after receipt of the initial denial. You may have missed the filing deadline for an expedited appeal, or you may not need an expedited review. In this case, Health Net will issue a determination letter within 30 days after your request for review is received indicating the decision and any further rights you may have. All

prior authorization appeals should be sent to the address below, which is also provided in the denial letter.

Mail prior authorization appeals to:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE
Authorization Appeals
P.O. Box 870142
Surfside Beach, SC 29587-9742

### Hold Harmless

As a TRICARE Prime beneficiary, when you receive non-covered services from a network provider, you shall be "held harmless." This means that no payment will be required from you for these services unless you have been *properly informed* about the non-covered service in advance, and you have agreed in advance, and in writing, to pay for the non-covered service. However, it is your responsibility to know your TRICARE benefits. If you are unsure if a benefit is covered by TRICARE, be sure to talk to your doctor.

## Grievances

A grievance is a written complaint or concern on a non-appealable issue regarding a perceived failure by any member of the health care delivery team, including TRICARE or military providers, Health Net, or subcontractor personnel to provide appropriate and timely health care services, access, quality, or level of care or service.

The grievance process allows full opportunity to report in writing any concern or complaint regarding health care quality or service. Any TRICARE civilian or military provider, TRICARE beneficiary, sponsor, parent, or guardian or other representative of an eligible dependent child may file a grievance. The Health Net Clinical Quality Management (CQM) Department is responsible for the investigation and resolution of all grievances. Grievances are resolved no later than 60 days from receipt. Following resolution, the CQM Department will notify the party who submitted the grievance of the review completion.

Grievances may include such issues as:

- The quality of health care or services aspects like: accessibility, appropriateness, level, continuity or timeliness of care, effectiveness, or outcome
- The demeanor or behavior of providers and their staff
- The performance on any part of the health care delivery system
- Practices related to patient safety

Required information for grievances:

- The beneficiary's name, address, and telephone number
- Sponsor's or beneficiary's social security number
- Beneficiary's date of birth
- Beneficiary's signature
- A description of the issue or concern must include:
    - The date and time of the event
    - Name of the provider(s) and /or person(s) involved
    - Location of the event (address)
    - The nature of the concern or complaint
    - Details describing the event or issue
    - Any appropriate supporting documents

Additional requirements when submitted by someone other than the involved beneficiary:

- The involved beneficiary must sign the grievance, or
- The beneficiary must complete, sign and mail or fax the Acknowledgment for Health Net to Review Grievance Form, available on the Health Net Web site at www.healthnetfederalservices.com. You can also submit the form through the Health Net Web site.

Mail grievances to:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE Grievance
P.O. Box 870150
Surfside Beach, SC 29587-9750

## Assistance with Collection Activities

Debt Collection Assistance Officers (DCAOs) are located at the TRICARE Regional Office—North and each military treatment facility (MTF) to assist you in resolving health care collection-related issues. If you receive a bill from a provider that is incorrect, contact the provider first to try to resolve the issue.

You must bring or submit documentation associated with a collection action or adverse credit rating to the DCAO for assistance. This includes debt collection letters, explanation of benefits statements, and medical/dental bills from providers. The more information you can provide, the faster it will be to determine the cause of the problem. The DCAO will research your claim, provide you with a written resolution of your collection problem, and inform the collection agency that action is being taken to resolve the issue.

DCAOs cannot provide legal advice or fix your credit rating, but they can help you through the debt collection process by providing documentation for the collection or credit-reporting agency in explaining the circumstances relating to the debt. To find a DCAO near you, visit the DCAO directory online at www.tricare.osd.mil/DCAO.

## Fraud and Abuse

TRICARE regulations require that all potential fraud and abuse must be reported to the Health Net Program Integrity Department. Fraud is a deception or misrepresentation by a provider, beneficiary or sponsor with the knowledge that such deception or misrepresentation could result in an unauthorized benefit or payment. Abuse is any practice that is inconsistent with sound fiscal, business or professional practice, which results in unnecessary costs or payment. Some examples of health care fraud include the following items, and all are punishable by law:

- Altering bills or receipts
- Misrepresentation of services or diagnosis in order to increase payments
- Accepting payments or other items of value in exchange for patient referrals
- Arrangements for commissions, fee-splitting or kickbacks
- Misrepresenting the true identity of the provider on claims
- Billing for services that represent flagrant over-utilization
- Waiving of cost-shares or deductibles
- Refusal to allow Health Net access to records related to TRICARE claims
- Failure to maintain adequate medical or financial records
- Billing component parts of a procedure rather than billing a single code that encompasses the entire procedure, known as unbundled billing

To investigate any allegation of fraud, the Health Net Program Integrity Department must have the following information:

- Who committed the fraud
- When the fraud occurred (timeframe)
- Where the fraud occurred
- Detailed description of the fraudulent activity

All reports of fraud and abuse undergo an exhaustive review process before any action is taken. Serious cases of fraud and abuse are reported to the Government for criminal investigation and prosecution. Report an incident or learn more about fraud and abuse through one of four resources:

- Call the Health Net Fraud and Abuse Hotline at 1-800-977-6761
- Send an e-mail message to *program_integrity@health.net*
- Visit the Health Net Web site at www.healthnetfederalservices.com
- Mail information to the following address:

Health Net Federal Services, Inc.
Attn: Program Integrity
P.O. Box 870147
Surfside Beach, SC 29587-9747

# For Information and Assistance

## Regional Information Resources

### Health Net Federal Services, Inc.

You can access TRICARE program information and general health and wellness resources 24 hours a day, seven days a week, by visiting the Health Net Web site at www.healthnetfederalservices.com. You may also call Health Net toll free at 1-877-TRICARE (1-877-874-2273) for customer service assistance between the hours of 8 a.m. and 7 p.m. Eastern time and 7 a.m. and 6 p.m. Central time. Through the Web site and toll-free line, you can find important TRICARE information and get your questions answered regarding eligibility, TRICARE Prime enrollment, benefits and copayments, what services require a referral or prior authorization, health care claims payment, and any other type of TRICARE inquiry. Health Net offers the AudioHealth Library featuring hundreds of recorded health topics which can help you stay healthy. Topic codes are listed online at www.healthnetfederalservices.com or you can request a brochure through the toll-free customer service telephone line. TRICARE Service Centers (TSCs) are also located throughout the North Region to assist you with the TRICARE program. PGBA, LLC (PGBA) maintains the www.mytricare.com Web site, which also offers important TRICARE program information and claims processing.

### TRICARE Service Center Directory

TSCs are located throughout the TRICARE North Region and are staffed with customer service representatives to assist you. There is a TSC locator available through the Health Net Web site (www.healthnetfederalservices.com) that provides specific driving directions from your location to the nearest TSC. If you are unable to visit a TSC, the "Online TRICARE Service Center" is available through the Health Net Web site, allowing you to conveniently access TSC services from the comfort of your home. TSC services are also available through the toll-free TRICARE customer service line at 1-877-TRICARE (1-877-874-2273).

### Health Net Provider Directory

The Health Net Web site (www.healthnetfederalservices.com) features an online directory of military treatment facilities (MTFs) and network providers. It is updated weekly to reflect the most current provider information. The directory contains the provider's name, specialty, address, telephone number, gender, whether the provider is accepting new patients, and driving directions from your location to the provider's office. The directory's search capabilities can be personalized for your needs to include your name, the specific type of provider selected, and desired characteristics of the provider. Once your search is completed, you receive a customized directory that you can view and/or print for your needs. If you do not have Internet/Web access, you can call the toll-free customer service line at 1-877-TRICARE (1-877-874-2273) or visit a TSC for assistance in locating an MTF or network civilian provider.

## National Information Resources

### TRICARE Web Site www.tricare.osd.mil

You can consult TRICARE's trusted online resource for the most up-to-date information about TRICARE. Learn about TRICARE program options, policies and guidance, and the latest news and events.

### TRICARE Online www.tricareonline.com

The Department of Defense's (DoD's) Internet portal to TRICARE and health care information, TRICARE Online is available to all TRICARE beneficiaries. Registered users can even book appointments online.

### TRICARE Information Service 1-888-DoD-CARE (1-888-363-2273)

Customer service representatives are available Monday–Friday (except federal holidays) from 8 a.m. to 8 p.m. Eastern time to answer your questions. An interactive voice response (IVR) feature, available 24 hours a day, seven days a week, works with the TRICARE Information Service and offers you access to commonly requested TRICARE eligibility information. It also offers assistance finding the appropriate partner call center for specific issues. With the TRICARE IVR, callers may request TRICARE information by saying the number of the option they wish to hear about or by using a touch-tone telephone keypad.

# Beneficiary Tools

## Common TRICARE Acronyms

| | |
|---|---|
| ADFM | Active Duty Family Member |
| ADSM | Active Duty Service Member |
| BCAC | Beneficiary Counseling and Assistance Coordinator |
| CHCBP | Continued Health Care Benefit Program |
| DCAO | Debt Collections Assistance Officer |
| DEERS | Defense Enrollment Eligibility Reporting System |
| DMDC | Defense Manpower Data Center |
| DoD | Department of Defense |
| DSO | Defense Manpower Data Center (DMDC) Support Office |
| EOB | Explanation of Benefits |
| HMHS | Humana Military Healthcare Services |
| MHS | Military Health System |
| MTF | Military Treatment Facility |
| NOAA | National Oceanic and Atmospheric Administration |
| OHI | Other Health Insurance |
| PCM | Primary Care Manager |
| PDTS | Pharmacy Data Transaction Service |
| PGBA | PGBA, LLC |
| PHS | Public Health Service |
| POS | Point-of-Service |
| RC | Reserve Component |
| SPOC | Service Point of Contact |
| TAMP | Transitional Assistance Management Program |
| TDP | TRICARE Dental Program |
| TFL | TRICARE For Life |
| TMA | TRICARE Management Activity |
| TMOP | TRICARE Mail Order Pharmacy |
| TPR | TRICARE Prime Remote |
| TPRADFM | TRICARE Prime Remote for Active Duty Family Members |
| TRDP | TRICARE Retiree Dental Program |
| TRO | TRICARE Regional Office |
| TRRx | TRICARE Retail Pharmacy Program |
| TSC | TRICARE Service Center |
| UCCI | United Concordia Companies, Inc. |
| USFHP | Uniformed Services Family Health Plan |
| USPHS | United States Public Health Service |
| WPS | Wisconsin Physicians Service |

## Glossary of Terms

### *Allowable Charge, also TRICARE Allowable Charge*

The term "allowable charge" is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The allowable charge is normally the lowest of the actual billed charge or the allowable charge. For example, if the allowable charge for a service is $90 and the billed charge is $50, TRICARE will pay $50 (actual billed charge); if the billed charge is $100, TRICARE will pay $90 (the allowable charge). In the case of inpatient hospital payments, the diagnosis-related group (DRG) is the TRICARE allowable charge regardless of the billed amount.

### *Authorized Provider*

An authorized provider is a hospital or institutional provider, a physician or other individual professional provider, or other provider of services, meeting specific educational, licensing, and other requirements. Authorized providers are not necessarily network providers. TRICARE will share costs if a beneficiary sees a provider of this type.

### *Balance Billing*

A term used to describe when a provider bills a beneficiary for the rest of the charges. A beneficiary cannot be billed for the remainder or 'balance' of the provider charges after TRICARE (and other health insurance) has paid everything it's going to pay. A beneficiary is not legally responsible for amounts above 15 percent of the TRICARE allowable charge, even if the provider is not network and does not accept assignment of benefits. Network providers are prohibited from balance billing.

### *Beneficiary*

A person who is eligible for TRICARE benefits. Beneficiaries include active duty service members, active duty family members (ADFMs), retired service members, and their families. Family members include spouses and unmarried natural or stepchildren up to the age of 21 (or 23 if full-time students at accredited institutions of learning). Other beneficiary categories are listed in the section entitled, "Eligibility for TRICARE."

### *Beneficiary Counseling and Assistance Coordinators (BCACs)*

Persons at military treatment facilities (MTFs) who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors or HBAs.

### *Case Management*

A collaborative process normally associated with multiple episodes of health care intervention which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a beneficiary's complex health needs. This is accomplished through communication and available resources that promote quality, cost-effective outcomes.

### *Catastrophic Cap*

The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (October 1–September 30). The catastrophic cap for active duty families is $1,000, and the catastrophic cap for all other TRICARE eligible families is $3,000.

### *Certified Provider*

A certified provider is one that meets all the requirements to be a TRICARE-authorized provider and has been "certified" to provide services to TRICARE beneficiaries. "Authorized" and "certified" are interchangeable terms.

### *Copayment*

The fixed amount a TRICARE Prime* enrollee will pay for care in the civilian provider network. Active duty service members and active duty family members are not required to pay copayments for services received from a network provider under TRICARE Prime.

**Includes TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members.*

### *Cost-Share*
The percentage of the allowable charges a beneficiary will pay under TRICARE Extra and Standard. The cost-share depends on the sponsor's status—active duty or retired.

### *Deductible*
The annual amount a TRICARE Extra or TRICARE Standard beneficiary must pay for covered outpatient benefits before TRICARE begins to share costs. TRICARE Prime and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) beneficiaries do not have an annual deductible, unless they are utilizing their point-of-service (POS) option.

### *Enrollee*
A TRICARE-eligible beneficiary who has elected to enroll in TRICARE Prime, TRICARE Prime Remote (TPR), TPRADFM, or the Uniformed Services Family Health Plan.

### *Explanation of Benefits (EOB)*
A statement sent to beneficiaries showing that claims were processed and the amount paid to providers. If denied, an explanation of denial is provided.

### *Health Care Finder (HCF)*
Representatives who help locate TRICARE providers and applicable community, state, and federal health care resources for beneficiaries who require benefits and services beyond TRICARE.

### *Military Treatment Facility (MTF)*
A medical facility operated by the military that may provide inpatient and/or ambulatory care to eligible TRICARE beneficiaries. MTF capabilities vary from limited acute care clinics to teaching and tertiary care medical centers.

### *Network Provider*
A network provider is a civilian provider who has signed a contracted agreement to be part of the "network" of providers who participate in the TRICARE program. These providers typically administer care to TRICARE Prime beneficiaries and those beneficiaries using TRICARE Extra (the preferred provider option). A network provider accepts the negotiated rate as payment in full for services rendered.

### *Nonavailability Statement (NAS)*
A certification from an MTF that a specific health care service or procedure cannot be provided.

### *Non-network Provider*
A non-network provider is one who has no contractual relationship to provide care to TRICARE beneficiaries, but is authorized to provide care to TRICARE beneficiaries. A non-network provider must be authorized. There are two types of non-network providers—"participating" and "non-participating."

### *Nonparticipating Provider*
A nonparticipating provider is an authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to TRICARE beneficiaries, but who has not signed a contract and does not agree to "accept assignment." A nonparticipating provider may balance bill.

### *Other Health Insurance (OHI)*
Any non-TRICARE health insurance that is not considered a supplement. This insurance is acquired through an employer, entitlement program, or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, or other programs or plans as identified by TRICARE Management Activity (TMA).

### *Participating Provider*
Providers who participate in TRICARE, also called "accepting assignment," and agree to accept the TRICARE-determined allowable cost or charge as the total charge for services—also known as the TRICARE allowable charge as the full fee for care. In the case of network providers, the negotiated rate is considered the full fee for care. Non-network, individual providers may participate on a case-by-case basis. Providers

may seek applicable copayments, cost-shares, and deductibles from the beneficiary. Hospitals that participate in Medicare must, by law, also participate in TRICARE for inpatient care. For outpatient care, they may or may not participate.

### *Point-of-Service (POS)*
An option that allows a TRICARE Prime beneficiary to obtain medically necessary services—inside or outside the network—from someone other than his or her primary care manager, without first obtaining a referral or authorization. Utilizing the POS option results in a deductible and greater out-of-pocket expenses for the beneficiary.

### *Pre-Authorization*
See the definition for Prior Authorization.

### *Primary Care Manager (PCM)*
A TRICARE civilian network provider or military treatment facility (MTF) provider who provides primary care services to TRICARE beneficiaries. A PCM is either selected by the beneficiary or assigned by an MTF commander or his or her designated appointee. To the extent consistent with governing state rules and regulations, PCMs can include internal medicine physicians, family practitioners, pediatricians, general practitioners, obstetricians, gynecologists, physician assistants, nurse practitioners, or certified nurse midwives.

**Note:** TPR and TPRADFM beneficiaries may choose a TRICARE authorized provider if a network provider is not available.

### *Prime Service Area*
Formerly was called catchment area defined to be within a 40-mile radius (determined by ZIP code) of a military treatment facility (MTF). It now also includes areas containing a high concentration of TRICARE beneficiaries and who are not within the catchment area of an MTF. Health Net is required to offer TRICARE Prime in each prime service area.

### *Prior Authorization*
A review determination made by a licensed professional nurse or paraprofessional for requested services, procedures, or admissions. Prior authorizations must be obtained prior to services being rendered or within 24 hours of an admission.

### *Referral*
The process by which a primary care manager (PCM) refers a TRICARE Prime beneficiary to another professional or ancillary provider for specialized medical services, prior to those services being rendered.

### *Regional Contractors*
TRICARE civilian partners who provide health care services and support in the TRICARE regions (TriWest Healthcare Alliance, Health Net Federal Services, Inc., and Humana Military Healthcare Services, Inc.).

### *Reserve Component (RC)*
The RC includes the Army National Guard, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the U.S. Coast Guard Reserve.

### *Split Enrollment*
Refers to multiple family members enrolled in TRICARE Prime in different TRICARE regions

### *Sponsor*
The active duty service member (ADSM) or retiree through whom family members are eligible for TRICARE.

### *Supplemental Insurance*
Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) plans, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

## Procedures and/or Services Requiring Prior Authorization

### TRICARE Prime*

#### Inpatient Procedures

- All elective acute inpatient admissions
- All non-emergent admissions for substance abuse or behavioral health
- All emergency admissions require notification to Health Net within 24 hours of admission or by the next business day

#### Outpatient Procedures and Equipment

- Adjunctive dental care
- Chelation therapy
- Durable medical equipment (DME), orthotics, and prosthetics
    - Purchase, when ≥ $500 billed charges
    - Rental, when the purchase price is ≥ $500 billed charges
- Hearing aid services (bone anchored hearing aids)
- Home health services
- Hospice
- Non-network providers (services on the prior authorization list for TRICARE Prime beneficiaries performed by non-network providers after the initial approved referral)
- New and evolving technology or experimental services
- Nutritional therapy
- Obstetrics and Gynecology (radiology, global and high-risk maternity, and sub-total hysterectomy)
- Oral surgery
- Program for Persons With Disabilities (PFPWD)
- Psychiatric (psychotherapy, psychoanalysis, electroconvulsive therapy [ECT])
- Radiology (magnetic resonance imaging [MRI], magnetic resonance angiography [MRA], positron emission tomography [PET], and single-photon emission computed tomography [SPECT])
- Reconstructive, plastic, or cosmetic surgery
- Rehabilitation
    - Cardiac and pulmonary rehabilitation
    - Occupational, physical, and speech therapy
- Surgery for morbid obesity
- Transplants—all solid organ and stem cell transplants (excludes corneal)

**Includes TRICARE Prime Remote, and TRICARE Prime Remote for Active Duty Family Members*

### TRICARE Extra and Standard

#### Inpatient Procedures

- All non-emergent admissions for substance abuse or behavioral health
- All admissions for adjunctive dental care, transplants, PFPWD

#### Outpatient Procedures and Equipment (at MTF or in the network)

- Adjunctive dental care
- Home health services
- Hospice
- Psychiatric (psychotherapy, psychoanalysis, electroconvulsive therapy [ECT])
- Transplants—all solid organ and stem cell transplants (excludes corneal)

# Index


## A

Abortion, 26
Abuse, 20, 34, 41
Abuse Hotline, 34
Accident, 20, 29
Activated, 4, 6, 9
Active duty family member, 4, 6-9, 11, 13, 15-19, 23, 28, 37-39, 41
Active duty service member, 1, 4-17, 19, 23, 26-28, 30, 37-41
Acupuncture, 27
Adenomas, 20
Adjunctive dental care, 26, 29, 41
Allergy tests, 17
Allowable charge, 8, 11, 16-18, 23, 28-29, 38-39
Amblyopia, 19
Ambulance services, 16
Ambulatory surgical facility, 16
Annual enrollment, 6, 8
Appeals, 29-30, 32-33
Artificial insemination, 27
Assignment, 8, 16-18, 23, 32, 38-39
Attending physician, 26
Authorized provider, 8, 27, 38-40
Authorized reimbursement, 7
Autopsy services, 27

## B

Baby, 22
Balance billing, 8, 16-18, 23, 38-39
Behavioral health care, 15, 21, 23-24, 26, 29, 41
Beneficiary Counseling and Assistance Coordinator, 37
Billed charge, 16-18, 23, 34, 38
Birth, 5, 19, 21-22, 26-27, 33
Birth control, 27
Brand-name medications, 24-25
breast exams, 19

## C

Camps, 27
Cancer, 19-22
Caps, 21
Cardiac rehabilitation, 26
Catastrophic cap, 18, 21, 28-29, 38
Catchment area, 40
CDC, 20-21
CHCBP, 14, 22, 37
Chiropractic Care Program, 26
Civilian facility, 10, 18, 22, 24, 36, 38-40
Claims, 5-6, 10, 29-31, 34-35, 39-40
Claims processing, 30, 35
Clinical preventive services, 6, 17, 19-21
Co-morbidity, 27
Collections, 34, 37
Colon rectal cancer, 20
Concordia Companies, Inc, 11, 37
Contact lenses, 27
Copayment, 6, 8, 11, 15-25, 28, 35, 38, 40
Cost-share, 6, 8-11, 13-23, 25, 28-29, 34, 38-40
Counseling services, 18, 20, 27, 37-38
Couples therapy, 27
Covered services, 6, 9, 11-17, 19, 24, 26-29, 32-33, 39

## D

Debt collection, 34, 37
Debt Collections Assistance Officer (DCAO), 34, 37
Deductible, 6, 8-9, 11, 13-17, 19-23, 25, 28-29, 34, 39-40
DEERS, 4-6, 10, 37
Denial letter, 32-33, 39
Dental care, 6, 11-12, 20, 26-27, 29, 41
Dental treatment facilities, 11
Description of balance, 16-18
Determination letter, 32
Detoxification, 23
Diabetes, 27
Diagnosis-related group, 27, 38
Disability, 13, 15, 27, 41
Disenrollment, 6
Divorce, 5
Doctor, 7-8, 32-33
Dual-eligible, 10, 30
Durable medical equipment, 16, 41

## E

Education, 20, 22, 27
Elective psychotherapy, 27
Eligibility, 4-6, 8-14, 22, 33, 35-39
Emergency, 7, 11-12, 15-16, 32, 41
Enrollment, 4-13, 19, 35, 37-40
Enrollment fees, 6, 8, 11-13
Explanation of benefits, 10, 21, 29-30, 32, 34, 37, 39

Explanation of denial, 39
Express Scripts, Inc., 24-25
Extended Care Health Option (ECHO), 13
Eye examinations, 12, 17, 19, 27
Eyesight-threatening emergency, 15

## F

Family member, 1, 4-17, 20, 22-23, 25, 27-29, 37-41
Fecal occult blood testing, 20
Federal health care resources, 39
Fee-for-service option, 8
Fiscal year, 11, 18, 23, 28, 38
Food substitutes, 27
Foot care, 27
Former spouses, 4, 6, 11, 14, 28
Fraud, 34

## G

Gastric bypass, 27
Generic medications, 24
Genetic testing, 27
Glaucoma, 19
Grievance, 33
Gynecologists, 40

## H

HBsAg, 22
Health Benefits Advisors, 38
Health Care Finder, 39
Hearing aid, 41
Hepatitis, 21-22
HIV, 21
Home health care, 16-18, 41
Hospice care, 18
Hospital, 5, 7-8, 12, 15-16, 18, 21, 23, 27, 32, 38-40
Hospitalization, 7, 18, 23

## I

ID card, 5, 24
Immunizations, 17, 20-22
Indian Health Service, 29, 39
Individual Ready Reserve, 11
Infant, 5, 19, 21-22
Infectious disease screening, 21
Inpatient care, 11, 15, 18, 23, 28, 32, 38-41

## L

LASIK, 27
Licensed Professional Counselors, 23
Limited acute care clinics, 39
Lockout provision, 6

## M

Mammograms, 20
Managed care, 12
Marriage, 5
Mastectomy, 26
Maternity care, 15, 18, 22, 41
Maximum allowable charge, 16-18, 23
Medicaid, 29, 39
Medical necessity, 24
Medicare, 4, 9-10, 12-13, 17-18, 24, 30, 40
Medications, 13, 15-16, 18, 23-25, 40
Meningococcal meningitis, 21
Mental illness, 23
Military dental treatment facilities, 11
Military treatment facility, 1, 6, 15, 26, 30, 34, 36-40
Mind expansion, 27

## N

National Defense Authorization Act, 11
National Guard, 11, 40
National Oceanic and Atmospheric Administration (NOAA), 4, 37
Naturopaths, 27
Network pharmacies, 13, 24-25
Network provider, 4, 7-8, 11-12, 19-21, 24, 30, 32-33, 36, 38-40
Newborn, 5, 21-22
Nonavailability statement (NAS), 11, 23, 39
Nonemergency, 6, 8, 11, 23, 28
Non-covered services, 33
Non-network pharmacies, 10, 24-25, 28
Non-network provider, 30, 39
Nonparticipating provider, 8, 39
Nutrition, 20
Nutritional therapy, 41

## O

Obstetric, 22, 41
Obstetricians, 22, 40
Occupational therapy, 17
One-year lockout, 6
Ophthalmologist, 19
Optometrist, 19

Oral surgery, 41
Orthomolecular psychiatric therapy, 27
Other health insurance, 28-29, 37-40
Out-of-pocket, 6, 21, 28-29, 38, 40
Outpatient care, 15-17, 20, 23, 27-28, 38, 40
Overseas travel, 17, 20
Overseas travel immunizations, 17

## P

Pain management, 22
Pap smear, 19-21
Partial hospitalization, 23
Pastoral counselors, 23
Patient health records, 6
Pediatricians, 40
Pelvic exams, 19
PFPWD, 13-15, 27, 29, 41
Pharmacy, 10, 13, 15, 24-25, 28, 37
Physical therapy, 17
Physicians, 12, 16, 18, 23-24, 26, 30, 37-40
Point-of-service, 6-8, 15, 25, 28-29, 32, 37, 39-40
Pregnancy, 22
Prenatal care, 18, 22
Prescriptions, 10, 13, 24-25, 28
Preventive services, 6, 17, 19-21
Primary care manager, 4, 6-8, 15, 19, 24, 37, 40
Prime service area, 6-7, 40
Prior authorization, 15-18, 23-24, 29, 32-33, 35, 40-41
Privacy, 22
Prostate Specific Antigen, 19
Prosthetic devices, 16
Providers, 4, 6-8, 10-13, 15-24, 27, 29-30, 32-34, 36, 38-41
Psychiatric treatment, 27
Psychological evaluations, 27
Pulmonary rehabilitation, 26, 41

## R

Radiology services, 16, 18, 41
Reconstructive surgery, 26
Referral, 6-8, 15, 19-21, 24, 29, 34-35, 40-41
Regions, 4, 7, 13, 15, 30, 40
Rehabilitation, 17, 23, 26, 41
Reimbursement, 7, 16-18, 23, 25, 27-28
Reserve Component, 1, 4, 6, 9-11, 14, 37, 40
Residential Treatment Center, 23
Retail network pharmacy, 13, 25
Retirees, 4-6, 8, 11-13, 16-18, 23, 28, 37-38, 40
Routine care, 6, 17, 19, 21, 27

## S

Screenings, 19-22, 25
Sexual dysfunction, 27
Sexual inadequacy treatment, 27
Short-term acute patient care, 18
Skilled nursing facility, 17-18
Skin cancer exams, 20
Social Security number, 32-33
Specialty care, 6-7, 12, 15, 17-19, 36
Speech therapy, 17-18, 41
Sponsor, 5-7, 9-14, 17, 22, 32-34, 39-40
Substance abuse, 20, 23, 41
Supplements, 27, 29, 39
Surgical care, 15-18, 26-27, 41
Survivors, 1, 6, 12, 28

## T

Terminal illness, 18
Tetanus, 21
Third Party Liability, 29-30
Transitional Assistance Management Program (TAMP), 14, 22, 37
Transitional health care benefits, 14
Transplants, 29, 41
TRICARE, 1-2, 4-41
TRICARE allowable charge, 8, 11, 28-29, 38-39
TRICARE authorized provider, 40
TRICARE costs, 15, 21, 25, 28-29
TRICARE Dental Program, 11, 13, 37
TRICARE Extra, 4, 8-10, 16-23, 28, 39, 41
TRICARE For Life, 4, 9-10, 13, 30, 37
TRICARE Mail Order Pharmacy (TMOP), 10, 13, 24-25, 37
TRICARE Management Activity, 11, 29, 37, 39
TRICARE Overseas, 13
TRICARE Pharmacy Program, 10, 15, 24
TRICARE Plus, 10
TRICARE Prime, 4-13, 15-23, 25, 27-29, 32-33, 35, 37-41
TRICARE Prime Remote (TPR), 4-5, 8-10, 15-18, 27-28, 37-41
TRICARE Prime Remote for Active Duty Family Members (TPRADFM), 4, 8-9, 15-18, 28, 37-41
TRICARE Regional Office, 7, 34, 37
TRICARE Retiree Dental Program, 11, 37
TRICARE Service Center, 6, 35-37
TRICARE Standard, 4-5, 8-11, 13-14, 16-23, 25, 28, 30, 39-40

## U

Uniformed services, 1, 4-5, 11-12, 14, 24, 37, 39
Uniformed Services Treatment Facilities, 12
Unremarried former spouses, 14
Urgent care, 6, 15
Uniformed Services Family Health Plan (USFHP), 4, 12, 37, 39

## W

Well-child Care, 19, 21
Wisconsin Physicians Service, 30, 37

## X

X-rays, 17-18, 26

# Notes

# Notes

# Notes

***Please provide feedback on this handbook at:***
http://www.tricare.osd.mil/evaluations/handbooks

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***www.healthnetfederalservices.com***

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1-877-TRICARE (1-877-874-2273)

TRICARE Information Service
1-888-DoD-CARE (1-888-363-2273)

TRICARE Mail Order Pharmacy *(Express-Scripts)*
1-866-DoD-TMOP (1-866-363-8667)

TRICARE Retail Pharmacy *(Express-Scripts)*
1-866-DoD-TRRx (1-866-363-8779)

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